THE EXPERIENCES OF AN ASYLUM DOCTOR

THE EXPERIENCES *of* *an* ASYLUM DOCTOR

WITH SUGGESTIONS FOR ASYLUM AND LUNACY LAW REFORM

BY

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TO ALL THE INSANE POOR

IN SYMPATHY WITH THEIR SUFFERINGS

AND IN HOPE OF ALLEVIATING THEIR HARDSHIPS

THIS BOOK IS INSCRIBED

BY THE AUTHOR

ERRATUM

The statement on p. 137 that the Board of Control is responsible to the Home Secretary as well as the Lord Chancellor is now no longer correct. According to the Ministry of Health Act (1919) all the powers of the Home Secretary in lunacy are apparently now transferred to the Minister of Health.

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INTRODUCTION

NOTE.—It has not been thought necessary to refer to the two asylums mentioned in this book by name. Both were well-known County Asylums. My term of office in the first asylum lasted about two years, in the second about two months. My official duties in both asylums were confined to the male side; in the second asylum I had occasional charge of the female side as well. I should also like to state that all cases referred to in this book are those of actual patients who are now or were once in the asylum, and whose history is in the Case Books. For obvious reasons their names are not given.

As I shall have occasion in the course of this book to quote frequently from the late Dr. Charles Mercier's excellent treatise, *Lunatic Asylums, their Organization and Management*, I cannot do better than commence this treatise by transcribing from that volume the following admirable summary of the objects he had in view when writing it. The late Dr. Mercier was not only an old asylum Superintendent himself, he was one of our foremost alienists, with a great reputation both in the United States and on the Continent. He was besides a man of very marked intellectual ability, of wide and diverse knowledge, and of great administrative capacity. Although I did not always see eye to eye with him in scientific and psychological questions, and have broken many a lance with him in controversial tourney in the medical papers, there was no man for whose opinion I had a greater respect. What he wrote was always of sterling value, though one might not always agree with it, and what he did not know of

asylum management in his own day was, with one or two notable exceptions, hardly worth knowing.

The work, from which the following quotation is taken, was written more than a quarter of a century ago, and is of added interest as showing how far, or how little, we have progressed since that date in our methods of asylum government and in our institutional treatment of the insane. Much of it, indeed, is an interesting comment upon the views expressed in this volume. The quotation is from the Preface to Dr. Mercier's book, and may well form part of the introduction to mine.

Dr. Mercier writes:—

> The whole tendency of the modern methods of the management of the insane has been to approximate their mode of life as far as possible to that of the normal man. The process which began with knocking off the fetters and chains from the limbs of the lunatic has been continued and advanced by the successive removal of more and more restrictions, until he has at length been placed in a position of material comfort. But the process admits of being carried further, and neither the ambition of the alienist nor the conscience of the public will rest until the principle is recognized and carried into practice, *that no restriction is justifiable that is not required by the circumstances of the individual case.*
>
> To lodge the insane in a palatial building, to keep them warm and clean, well clothed, well fed, occupied and amused, all this is most excellent and admirable. Contrasted with the ancient treatment by whips and fetters it seems perfect. But " nothing is done while aught remains to do," and the provision and the amplitude of these material comforts must not blind us to the fact that in spite of them a large proportion of the patients are wretched. They are wretched because they are deprived of that most precious of all possessions—their liberty. That they are unfit to have complete liberty is manifest from the fact that the legal formalities for their detention in an asylum have been complied with; *but it by no means follows that they all, at all times, need the severe restriction which is the common rule in all asylums; and the direction in which improvement in the management of the insane will in the future be effected will be in the more careful study and attention given to individual cases, and the greater elasticity introduced into the system of control.*[1] *The times and seasons when greater liberty can be given*

[1] Italics mine.

will be watched for and taken advantage of, and the times when restrictions must be reimposed will be recognized. All the arrangements of the asylum will be made with special reference to the individuality of the patients, and will be rendered modifiable and adaptable to suit their individual needs. Management of patients by the gross will give way to management of the individual, and the object of the management will be to approximate the life of the insane to the life of the sane, as far as such approximation is possible. This is the direction in which the management of the insane is tending, and it is in recognition of this tendency, and to help it forward, that this book has been written.

That there is much here set forth that will be derided by the present managers of asylums as impracticable, the author does not doubt; but he has faith in the efficacy of the erection of an ideal as an object to be striven for, not doubting that, even if it be not attained, much advantage will result from every exertion towards it, however partially successful.

To the reader who, after finishing this book, turns back to these eloquent sentences, the statement of the objects which Dr. Mercier sets out to attain, and his prophetic anticipation of their probable and forthcoming attainment, will appear as the climax of unintentional irony, a veritable tragedy of prophetic non-fulfilment. There is hardly a fact, a hope, or an ideal which Dr. Mercier portrays, which the following pages do not shatter, and my own experience does not refute. Dr. Mercier speaks of the lunatic having now (!) been "placed in a position of material comfort," of his being "lodged in palatial buildings, kept warm and clean, well clothed and well fed, occupied and amused." I speak of the insane, at least in my experience, as housed in gloomy and often dilapidated barrack-asylums, more like prisons than palaces, badly fed, poorly clad, dirty and unkempt, mostly unoccupied, and certainly not amused. Dr. Mercier speaks of the "fitness for such patients to be detained in an asylum" as proved by the fact that "the necessary legal formalities have been complied with." I maintain, on the contrary, that as regards the justice of the continued detention in asylums of many of the

so-called insane, the compliance with the "necessary legal formalities" is often no safeguard, and that many paupers are not only sent to asylums, but are also detained in them, who ought never to have been so sent or detained. Dr. Mercier anticipates that more attention "will be given in future to individual cases"; that "greater elasticity will be introduced into the system of control"; that "more liberty" will be given and "fewer restrictions" imposed; that "management of patients by the gross will give way to management of the individual," etc., none of which eminently desirable events I shall show have yet taken place in the conduct of either of the two asylums with which I was connected, nor, I suspect, in the conduct of most other English provincial pauper asylums. But I must not anticipate further the contents of this book. When the reader has ascertained the facts it contains he will be able to judge for himself.

It is time, however, that I introduced myself to the reader and explained how I came to be interested in asylum work.

When the war broke out, I had only lately retired from general practice, and, wishing to "do my bit" of national service, looked about for some means of making myself useful. I was a year or so over the military age, even for civilian work in the Army, and military service was out of the question. But having been a life-long student of psychology, and hearing there was a great dearth of asylum doctors, I applied for, and soon afterwards obtained, the post of Assistant Medical Officer in one of our largest County Asylums. In this first asylum I only remained two months, as the work, a large part of which was purely clerical, was not to my taste; in the second asylum, to which I was appointed the year afterwards, I remained for nearly two years. It is from my experience in this second asylum, one of the largest in England, that the facts enumerated in this book have been chiefly taken.

Profoundly interesting as I found the study of insanity

and psychiatric problems to be, I was not long in either asylum before I realized that there was a problem of still more urgent interest and importance, viz., that of our treatment of the pauper insane, and, in fact, the whole problem of asylum administration and lunacy legislation. I had not occupied my position more than a few months before it became evident to me that the administrative system under which our public asylums were conducted, and as constituted by Act of Parliament, permitted the occurrence of grave defects and abuses, which appeared to be involved in the system itself, and which could not be rectified without far-reaching administrative and legislative reforms. I am aware, of course, that this was no new discovery; that for a long time past those concerned in asylum administration have admitted and deplored the fact, and that many papers contributed to medical journals, and discussions at meetings of the Medico-Psychological Society, have dealt with these and kindred matters. But though it was suspected that all was not well with our public (or private) asylums, or our treatment of the insane, no attempt has hitherto been made, so far as I know, to bring the subject to public notice. Yet this seems of equal, if not greater, importance than its discussion in the pages of medical reviews and at meetings of medical societies; for until the public realizes the paramount interest it has in the matter, it is not likely that much will be done. All reforms of public institutions depend in the last resort upon the rousing of public sentiment and the pressure of public opinion. It is not enough for specialists and experts to be satisfied of the necessity for reform; it is for the public itself to take the lead. But to do this the facts must be known. That the reform of asylum administration and lunacy legislation has made so little progress hitherto in this country is because the public are not cognizant of the facts, and thus are ignorant of the reasons for its necessity. This book, then, is an attempt to supply the facts and give the reasons, and

thereby enable the public to form a judgment and take action accordingly.

It is high time, in my opinion, that this attempt should be made. If our public asylums exist chiefly for the welfare and comfort, as well as the humane detention, of the insane poor, more especially if their purpose is not merely detention and restraint, but, where possible, remedial and curative treatment, then I have no hesitation in saying that, so far as my own experience goes, our present system of asylum administration is a failure. And from a fairly wide reading on the subject, and from many conversations with Assistant Medical Officers of other asylums, both public and private, I believe that my experience is in no sense unique. Our asylums detain, but they certainly do not cure; or if they cure, it is only by accident, so to speak, and in spite of the system, not as a result of it. This may seem a somewhat bold statement, and my qualifications for making it may be, and in certain quarters probably will be, challenged, but I have no doubt of its truth. It may be said, for instance, that from an experience of little more than two years, and confined to only two out of nearly a hundred asylums, I have not sufficient warrant for making sweeping generalizations which involve the condemnation of the whole administrative system of public asylums in this country. To which I can only reply that the two asylums in question were fully representative of their class, and sheltered between them some five thousand insane inmates, and that though my experience was confined to these two, it cannot be considered less representative than they were, or be justly ignored. Some public asylums, no doubt, are much better managed than others, but in all the same system prevails; [1] and it is the *system* I am attacking,

[1] I have no experience of Scottish asylums, but from information received, and upon which I can rely, they appear to be far ahead of those in England, with the possible exception of those in the Metropolitan area.

not individual asylums; it is principles, not persons. If I succeed in showing that in two at least out of a hundred asylums the defects and abuses inherent in the system prevailed, I shall have practically proved my point and justified my action; for what has been found to exist in even one case is possible in all.

I have said that it is principles I am attacking, and not persons, and I wish to emphasize this fact. I have stated nothing of which I was not myself an eye-witness, or for the accuracy of which I cannot personally vouch; and when I have drawn inferences from facts, it is from facts which I have myself observed, or which have been communicated to me by others who were in a similarly favourable position for observing them, and upon whose testimony I can rely. And where it has been possible, I have stated these facts in such a way that the intelligent, and even non-medical, reader can himself form a judgment upon them. Yet, as my experience was gained in individual asylums, and chiefly in that with which I was longest associated, it cannot avoid being a reflection upon the conduct of those particular asylums, and of those who were responsible for their management. But I disclaim any intention of making personal attacks upon individuals. I recognize only too clearly the defects inherent in all bureaucratic control, and the fact that individual Superintendents of asylums are not so much to blame as the system they have to administer.

But this book contains not only a criticism of asylum management, but suggestions for legislative reform, and here I feel that I am altogether on more uncertain ground. No doubt it is a somewhat ambitious and hazardous undertaking to criticize so vast and complex a system as our lunacy legislation. This latter is the product during at least two centuries of the most acute and learned legal minds, and it may seem, and presumably is, absurd and presumptuous for one with no legal training or experience to set himself up as a critic and reformer in

these matters. No one is more conscious of the fact than the writer, or of his incompetence for so great and difficult a task. But it is open to anyone, however humble, who has had some experience of the conditions which he is criticizing, to make tentative suggestions for reform; to show, or attempt to show, where in his opinion the existing legislation is defective; and this is all I have ventured to do. No one can study the Lunacy Acts of 1890 and 1891, and the Mental Deficiency Act of 1913, without realizing the pains taken by the Legislature to safeguard the interests of lunatics and imbeciles, and to provide for their wise and humane treatment in our public asylums; but no one, with any practical knowledge of lunacy and the problems of psychiatrics, can fail to realize also that these objects have been insufficiently considered and imperfectly attained in these Acts. The many amendments and additions to previous lunacy legislation made in these Acts is in itself evidence of the growth of experience, and presumptive of the necessity for further reforms, and it is not to be supposed that we have come to an end in these directions. In fact, the recent Report of the Lunacy Commission set up by the Government to inquire into these questions[1] contains suggestions for still further and more comprehensive reforms, to some of which I allude in the following chapters. No chain is stronger than its weakest link, and if I can bring evidence to show that there are several weak links in the existing chain of lunacy legislation, I shall have accomplished the purpose with which I set out, even though my particular suggestions for reform may not be practicable, or can be improved upon. What these suggestions are will be seen in the sequel.

It may occur to the reader that if, during the course of my term of office, I had early come to the conclusion that there were grave evils and defects in our system of

[1] The Sixth Annual Report of the Board of Control was not published until after this book was written.

asylum administration, and especially in the administration of those asylums in which I served, my proper duty would have been to point them out to the authorities, and failing any notice being taken of my complaints, to have resigned my post, and have communicated with the Board of Control. This course suggested itself to me more than once, and had the circumstances been normal, is that which I should probably have followed. But there were several important objections to it. In the first place, there was " a war on," and it would have been a waste of time, as well as a lack of patriotism, to call attention to abuses which might easily have been put down to the exigencies of the war, and which in any case it was impossible then to cope with. Secondly, I was merely that obscure and negligible person, a locum tenens, and held office purely at the pleasure of the Medical Superintendent, who could dismiss me at a week's notice for any cause that seemed good to him, and who, had I made any complaints against the administration of the asylum, which would have been equivalent to making complaints against himself as administrator, would no doubt have dismissed me on the spot. And as my object was to gain as much information as I could, in order to make the best use of it when the proper time came, I should have been defeating that object by any action that led to my summary dismissal. As to making complaints to the Board of Control, that course seemed to me equally impracticable. Not only were the Commissioners, like most Government officials, very much overworked, but they were themselves parts of the system which I was attacking. It seemed to me, for both these reasons, much better that I should stay on where I was as long as possible, and learn as much as I could of the conditions of asylum management and treatment of the insane, and then embody the results of my experience in a book addressed to the general public—which, in fact, is what I have done.

But the objection, briefly referred to above, that the facts which I have disclosed in the following pages might not be attributable to conditions that normally obtained in the asylums in question, but might be largely the result of the war, needs further comment, for if this were true, it would obviously be unjust to draw adverse conclusions from conditions which were only temporary, and for which the asylum authorities could not be held responsible. That there is much apparent plausibility in this objection I will not deny. It is unquestionable that the war had a great and disastrous effect upon the management of public asylums and upon the health and comfort of all those who as inmates of asylums, workhouses, jails, reformatories and what not, were, so to speak, pensioners of the State, and dependent upon the normal distribution and extent of the national resources for their comfort and well-being. And were the defects and abuses which I describe in this book, and which form the basis of my criticism, the result merely of the abnormal conditions produced by the war, much of that criticism would lose its point and pertinence. It is, for instance, beyond question that the quality and abundance of the food supply was gravely interfered with in all our public institutions, just as they were in all our homes, though, as I show in the sequel, it was not so much the poverty and scarcity of the food as its unfair distribution that so seriously impaired the vitality of the asylum inmates. Again, it was only to be expected that much necessary work on renovations and repairs had to be foregone during the war owing to the greatly increased cost of material and labour. There were also other difficulties, peculiar to asylums and suchlike institutions, which existed for the same reason, and were the cause of much discomfort and even suffering to their inmates. I allude to the shortage of doctors, the great diminution in the number of attendants, especially male attendants, and the enhanced price of drugs, surgical dressings, and other

necessaries. All these discomforts and disabilities could not be helped, and they reacted injuriously upon the efficiency of all asylums and Poor Law institutions, and upon the health and comfort of those who lived in them. But the evils to which I more especially refer in this volume, though unquestionably emphasized and exaggerated by the war, were not caused by it. They existed in full force before the war, and unless steps are taken to eradicate them, will exist in full force after it. For it is my contention, which I hope to make the reader share, that for most of the evils enumerated in this book our system of asylum administration, and our lunacy laws themselves, are primarily responsible, and not the exigencies of the war.

There is one more matter of great importance which it is necessary to allude to before bringing this Introduction to a close. One of the chief defects in our system of asylum government against which I protest is that it permits the Superintendent of an asylum to combine in his own person the dual offices of Medical Superintendent and Executive Chief. I maintain that the result of this arrangement is, in ninety-nine cases out of a hundred, to cause the purely medical duties of a Superintendent to be largely subordinated to his executive responsibilities, thus entailing an enormous loss of efficiency in the medical organization of the asylum and in the remedial treatment of the insane. One of the chief charges that I bring against the system is that Medical Superintendents are encouraged to neglect their purely medical duties, and that in consequence of this the patients under their charge do not receive at their hands that medical attention and care to which they are entitled. I am quite aware that it would be a serious matter to charge an officer of a great public institution with the neglect of his professional duties, especially when these duties have not been clearly defined and their performance has been left largely to his own discretion. But I make no such charge against

any individual officer. The law itself leaves much to be desired on this point. All that the Lunacy Act of 1890 says upon this matter is that the Visiting Committee shall appoint—

> A Superintendent of the asylum, or if there is more than one division, a Superintendent of each division of the asylum, who shall be the Resident Medical Officer, or one of the Resident Medical Officers of the asylum, or of the division of which he is appointed Superintendent, unless a Secretary of State authorize the Committee to appoint some other person than a Medical Officer to be Superintendent (Sect. 276).

There is no mention in the Act of any specific medical duties which the Superintendent is obliged to perform, but since the Act provides that he is to be "one of the Resident Medical Officers of the asylum" unless a non-Medical Superintendent is appointed, it follows that he must have *some* medical duties. Under this clause of the Act, however, the presumption is that the Medical Superintendent of an asylum has supreme medical authority over, and responsibility for, the medical conduct of such asylum; though to what extent the Visiting Committee shares in this authority and responsibility is not stated, and their duties in this respect are left equally vague. In any case, all Medical Superintendents of asylums assume this supreme authority, whether they legally possess it or not, and must be supposed to assume the responsibility that goes with it. If so, it follows that they have corresponding medical duties, for the one implies the other. What these duties are, and how they are apportioned between him and the assistant staff, is apparently left to the discretion of the Medical Superintendent, except where they have been laid down by the Visiting Committee. It is the contention of this book, however, that the nature of a Medical Superintendent's professional duties, as distinct from his executive duties, is a matter requiring the strictest official definition, and should not be left to the discretion or caprice of

any individual holders of this office. As things are at present, a Medical Superintendent can, if he pleases, entirely neglect the purely medical work of his asylum, and so long as his Committee are satisfied, no one can interfere with him. Yet that his medical duties are in reality paramount has been laid down in many books written upon this subject. In Chapter VII of this work, which deals with the Superintendent's office, there is quoted a long extract from Dr. Mercier's treatise on *Lunatic Asylums* dealing with the duties of Medical Superintendents, and to this chapter I must refer the reader. Suffice it to say here that Dr. Mercier regards as of primary and paramount importance the *medical* duties of this officer, and lays it down that they must everywhere and at all times take precedence of his purely executive duties. Among these specific duties, which involve in general "the care and treatment of the patients committed to his charge," Dr. Mercier includes—(1) a daily visitation of the wards *in the company of the Assistant Medical Officer*; (2) consultations with his subordinates over all obscure and difficult cases; (3) the performance of post-mortem examinations; (4) his presence at all important operations; (5) the "classification of the patients and the allocation of each patient to the ward in which he has to live"; (6) the inspection of the Case Books.

It is probable that most readers of this book will agree with Dr. Mercier and the present writer that, if a Medical Superintendent has any specific medical duties at all, those summarized above represent at least the irreducible minimum. There is one addition to this list which I should certainly make, as I regard it of equal, if not greater, importance than most of the others. I refer to the necessity of a regular consultation between the Medical Superintendent and his colleagues in the matter of the discharge of patients from the asylum. So important do I regard this matter that I have included it in the list of special reforms which, in my opinion, ought to be a

feature of the next Lunacy Act. It is totally contrary to every canon of reason and common sense, as well as prejudicial to the public interest, that a Medical Superintendent should be able to derogate to his Assistant Medical Staff practically the whole of the medical care of the patients, and yet should reserve to himself sole and unquestioned authority in a matter so vitally affecting their interests.

It may be objected, however, that where a Medical Superintendent has no specially defined medical duties, apart from the duty of general medical superintendence, it will not be easy for a charge of medical neglect to be brought against him. Such a Superintendent might argue thus: "I am the Superintendent of a lunatic asylum, and my duty is to superintend the medical and executive departments of the asylum. To assist me in the executive department I have a Chief Clerk and an Assistant Staff; to assist in the medical department I have a Senior Medical Officer and an Assistant Medical Staff. To the Medical Staff I delegate the practical medical work of the asylum. There is no more reason why I should personally undertake this work than that I should personally undertake the work of the clerical staff. My duty is to superintend and supervise, and for that alone I am responsible." To such a contention the only pertinent reply would be that it is not disputed, though the inferences drawn from it are. What *is* disputed is the implied assumption that the delegation of specific medical duties to his subordinates absolves a Medical Superintendent from any personal responsibility for them, or from any personal blame for their neglect: that he is in fact a *Medical* Superintendent only in name. I maintain, on the contrary, that no Medical Superintendent can thus abrogate his personal medical responsibility, and that he is always amenable to a charge of medical neglect. I assert unhesitatingly that whether or not the duties enumerated by Dr. Mercier, for instance, are

the proper duties of a Medical Superintendent, no Superintendent who persistently neglected them could be absolved from the charge of a general neglect of his official medical responsibility. But there are many other instances, apart from Dr. Mercier's list, where a charge of general medical neglect would lie against a Medical Superintendent, and such a charge it ought to be possible to bring. It is impossible in all such cases for the Medical Superintendent of an asylum to assert that the general medical care and treatment of the patients in the asylum is not in his hands, but has been delegated by him to his medical subordinates. Has he then delegated to them his supreme authority and responsibility? If he has not delegated the latter, neither can he delegate the former. He cannot have it both ways.

That much of the criticism offered in this book will be resented by most Medical Superintendents of public asylums goes without saying. They will say, no doubt, that for most of the evils of administration referred to in this book, if such exist, the war, and the war alone, was responsible. It may be objected, in particular, that for a Medical Superintendent to consult with temporary and for the most part inexperienced subordinates about the treatment of patients would have been useless and undignified. But even granting the fact that many of the men who acted as locum tenentes for the Assistant Medical Staff of our public asylums during the war were inexperienced and incapable, was that not all the more reason for a conscientious Superintendent to take more rather than less medical interest in his patients? But the reader of this book will not have gone far in his perusal of it without becoming convinced that in reality the war had little to do with the matter. I was told by one Medical Officer of more than twenty years' standing that the Medical Superintendent of his asylum had never, during the period in which my informant had held office, made a practice of holding official consultations with his

Assistant Staff in such matters as the discharge of patients; that he never accompanied them in their daily rounds; that he never himself performed or, except in the rarest instances, was present at the performance of post-mortem examinations or surgical operations, and that his habit of ignoring his medical subordinates, while leaving practically the entire medical charge of the patients in their hands, was a theme of universal comment and dissatisfaction among them.

The foregoing remarks have seemed necessary in view of the fact that so much stress has been laid in this book upon the system of "single control," and the combination in the person of the Medical Superintendent of most public asylums of the dual office of Medical Head and Executive Chief, and upon the disastrous results to the medical efficiency of the asylum that may and often do follow from it. If I cannot convince the reader of this fact, much of this book will have been written in vain. I go further, and assert that unless the Legislature lays it down in definite language that these two offices shall not be held in the same hands, no lasting improvement in the medical administration of public asylums is likely, or indeed is able, to follow. Many other reforms are urgently required in our lunacy legislation, but this one seems to me primary and essential.

In conclusion, I need only add that this book has not been written from the standpoint of the mental specialist. It is addressed to the general public, and is, as its name implies, not a psychiatric treatise, but a plea for asylum reform. Had it been addressed to the medical profession, it would have been very differently written.

The Experiences of an Asylum Doctor

CHAPTER I

LUNATIC ASYLUM ADMINISTRATION

As this book deals with the pauper lunatic, and purports to be an examination into the working of the Lunacy Act of 1890, 1891, and the Mental Deficiency Act of 1913, as far as these Acts apply to the maintenance and treatment of pauper lunatics and the administration of public asylums, it will be as well to give the reader in the briefest outline a résumé of the terms most commonly used and as legally defined, as well as a short description of the local bodies concerned in asylum administration, the officials appointed by the Legislature to supervise and report upon their work, and the legal formalities necessary for the certification and reception of pauper lunatics.

A "lunatic," under the Act, means "an idiot, or a person of unsound mind." A "pauper lunatic" may be either a "pauper" who becomes a lunatic, or a lunatic who in consequence of his affliction becomes a pauper. As the word "pauper" implies, he is one for whose maintenance the charges are defrayed either wholly or in part out of the rates.

An "asylum" means an asylum for lunatics provided by a county or borough, or by a union of counties or boroughs. An asylum is called "a County Asylum"

when provided by a single county, or by any county or counties in union with any borough or boroughs. In the latter case it is also called a "Borough or District Asylum." The supreme authority, under Parliament, of any County or District Asylum is vested in the Visiting Committee, supervised by the Board of Control. The Visiting Committee is appointed annually by the local authority, and consists of not less than seven members. The Visiting Committee of a District Asylum is constituted of the number of members fixed by the agreement under which the asylum is provided. Where, as in Lancashire, there is a County Asylums Board, that Board is constituted of the Visiting Committees of all the County and Borough Asylums.

The powers of the Visiting Committees are vested in them under the Local Government Act of 1888, and the Lunacy and Mental Deficiency Acts of 1890 and 1913, and are wide and varied in nature. They include the acquisition of land for the purpose of building asylums, the construction of these, the alterations, extension and repairs of the same buildings (though with limitation of annual expenditure as defined by the Act); the appointment and dismissal of all asylum officials, attendants, servants, etc., and the fixing of the scale of their salaries and wages; the apportioning of the weekly maintenance cost of the patients in the asylum (which must not in ordinary circumstances exceed fourteen shillings weekly), and which must be sufficient to defray in addition the salaries and wages of the officers and asylum servants, etc., and various other powers which need not now be specified, but will be referred to in subsequent pages of this book. Prominent among these is the power of discharging lunatics from the asylum "whether they are recovered or not," which is directly conferred on them under the Act (Lunacy Act of 1890, Sect. 77), and "with or without the advice of the Medical Superintendent." As will be seen from the above brief résumé, the powers

conferred on the Visiting Committee are considerable, and demand for their proper exercise judgment, tact, assiduity, integrity, business acumen, and a high sense of public duty.

The officials appointed by the Legislature to supervise and report upon all matters connected with the conduct of pauper asylums and the treatment of pauper lunatics are for all practical purposes the Commissioners in Lunacy alone. This body, known since 1913 as the Board of Control, consists [1] at present of five Medical Commissioners, a lady Commissioner, four legal Commissioners, three Medical Inspectors and a Secretary. Their duties are very onerous and far-reaching, including the visitation of all asylums and institutions for the insane, both public and private, once and in some cases twice every year, and the asylums in the Metropolitan area six times a year. One legal and one medical Commissioner are deputed for the purpose of each visitation (during the war there were modifications both in the number of visitations and the number of visitors), and one of their duties, as regards public asylums, is to draw up and issue an Annual Report or series of Reports, which are published by the Government printers, and are summarized in the leading daily papers. It will be observed that by far the largest part of the public administration of the Lunacy Acts is carried out under the supervision of the Board of Control. As the number of lunatics in the United Kingdom was in 1918 returned as 142,000,[2] it will be seen that the duties and responsibilities devolving on the Board of Control are sufficiently onerous, and it is probable that no body of public men or women is more hardly worked.

Other administrators of the Lunacy Acts are (1) the

[1] 1919.

[2] On January 1, 1920, the number of notified insane persons under care in England and Wales was 116,764. These figures show an increase of 9,200 over those of 1918.

Lord Chancellor's Visitors, (2) The Masters in Lunacy, (3) The "Judicial Authority," who may be either a Justice who has been especially appointed by his fellows, a local Stipendiary, or the County Court Judge.

1. The sole duty of the Lord Chancellor's Visitors concerns the visitation and supervision of persons who have been found of unsound mind by "inquisition." As the majority of these are persons of means, they are not met with in public asylums, but are either in private mental hospitals or under private care.

2. The Masters in Lunacy are solicitors of ten years' standing, and their powers, which are considerable, are concerned with the legal administration of the estates of those persons found insane by "inquisition," or in whose case a Receiver has been appointed.

3. The "Judicial Authority." The part taken by the "Judicial Authority," who may be either a Justice, a Stipendiary Magistrate, or a County Court Judge, is concerned with the signing of the reception order under which a supposed lunatic may be subjected to detention and treatment.

A lunatic may be detained according to one of six methods, three of which need only be mentioned here, viz., under (1) a *Reception Order*, (2) a *Summary Reception Order*, (3) an *Urgency Order*.

1. A *Reception Order* is an order signed by the judicial authority after the presentation of a petition by a "proper person," who should be a near relative, or the husband or wife of the supposed lunatic. The petition must be accompanied by a signed statement and by *two* medical certificates, the necessary forms for which are described in the Act.

2. A *Summary Reception Order* is an order signed by the judical authority in the case of a lunatic who is found "wandering," or otherwise misconducting himself. This is the usual form of order under which pauper lunatics are

admitted into public asylums or workhouses. The usual procedure is as follows:—

Every Medical Officer of a Union, who has knowledge that a pauper resident within his district is a lunatic, and a fit person to be sent to an asylum, must, under penalty of £10 (Lunacy Act 1890, Sect. 320) within three days give notice thereof to the Relieving Officer or (if there be none) to the Overseer. A Relieving Officer, or an Overseer, on becoming aware, either by notice from the Medical Officer or otherwise, that any pauper resident in the parish is a lunatic, must, under penalty of £10, within three days give notice to a Justice of the Peace. A magistrate, on being thus communicated with, must then deal with the case within three days, by examining the supposed lunatic. (*The Insane and the Law*, by Pitt-Lewis, Smith and Hawke, pp. 118, 119.)

For the purpose of this examination the magistrate must call in a medical man, and they must both make the examination together, and agree as to the course to be pursued. The examination may take place either in the alleged lunatic's own house, or "at any other convenient place." If both are agreed, the medical man signs the certificate, and the magistrate signs the reception order, by which the pauper lunatic may be conveyed either to an asylum (public or private) or the workhouse.

The usual practice is for the order for the alleged lunatic to be taken to a County or Borough Asylum, to be handed, when made, to the Relieving Officer or Overseer. The latter then usually takes the alleged lunatic into his charge, and conveys him or her to the proper asylum. The order of the Justice is sufficient authority for him to do this. On arrival at the asylum the order and certificate are examined by one of the responsible medical men on duty there, and if they are found to be in proper form, the lunatic is formally admitted as a patient, and the admission entered on the Register of Patients, and neglect to make this entry, or making a false entry, is a misdemeanour. (*The Insane and the Law*, p. 121.)

3. An *Urgency Order* is an order made in those cases "where it is essential either for the patient's own welfare, or for the public safety, that a patient shall be forthwith

placed under care and treatment" (*ibid.*, p. 101). This order may be signed by the husband, wife, or relative (if possible) of the alleged lunatic. It must be accompanied by *one* medical certificate, and holds good only for seven days, within which time a proper petition, accompanied by *two* medical certificates, must be presented to the judicial authority. As this form of order applies chiefly to private patients, it need not be further particularized. In the case of pauper lunatics the usual procedure is by a *Summary Reception Order*, as above described.

We will now trace the usual proceedings that follow in such a case. Having been apprehended by the police, taken to the nearest workhouse, examined by the magistrate and certified as insane by a medical practitioner (in this case usually the Medical Officer of the workhouse), the pauper lunatic is, within a period limited by the Act to fourteen days, conveyed by the Relieving Officer to the County or Borough Asylum. Arrived there, the lunatic is received by the Medical Officer on duty, the reception order is inspected, and if this is found to be correct, the patient is admitted. For this purpose he is taken to the Reception Ward, weighed, his clothes removed by the Head Attendant, and he is bathed. (This procedure is followed in the case of lunatics of either sex, but to simplify matters, and throughout this book, the case of male patients will alone be considered, though the reader will understand that everything that is described as occurring to a male patient applies equally to a female lunatic, with certain exceptions that are of no material consequence.) The patient's clothes are then collected, and they and his other belongings catalogued, the former being returned to the Relieving Officer, who gives a receipt for them and returns them to the workhouse authorities, who detain them until the patient is set at liberty. The personal belongings of the patient are taken charge of by the Clerk to the asylum, and returned to him when he leaves. The patient is then examined by the Medical

Officer, and his case is entered in the Reception Book in the office, together with details of his name, age, occupation, religious persuasion, social state, etc.

Should the patient be dangerous, or violent, or ill, he is at once put to bed in a private room in the Reception Ward, and the necessary treatment prescribed for him by the Medical Officer under whose care he is. After a stay in the Reception Ward of some days or weeks, according to the difficulties or necessities of the case and the exigencies of asylum accommodation, he is classified as belonging to such and such a type of mental unsoundness, and removed to the ward best suited to the treatment of his condition. This, I may state, is the proper procedure which should be followed in every case of admission, but, as we shall see in the sequel, this procedure, through lack of proper accommodation and defective organization, through shortage of doctors and attendants, and neglect of medical superintendence, was, in the asylums with which I was associated, more honoured in the breach than the observance, and led directly to many of the evils enumerated in this book.

We have now traced the career of the pauper lunatic from the time when his liberty has been forcibly taken away from him, and have given details of the legal procedure according to which he has been apprehended by the police, examined by the magistrate, medically certified as of " unsound mind," and sent for detention and treatment to one of our large County Asylums. His subsequent fortunes there form the subject of the following chapters.

Before following these further, however, a few remarks as to the number of lunatic asylums and kindred institutions for the insane existing in the United Kingdom, together with the number of lunatics contained in them, may not be without interest to the reader. The following list, the accuracy for which at the present date I cannot vouch, is copied from Dr. Weatherly's *Plea for the Insane,* which was published in 1918 :—

County and Borough Asylums [1]	98
Mental Hospitals	14
Military and Naval Hospitals	2
Criminal Asylums	2
Metropolitan Licensed Houses	21
Provincial Licensed Houses	42
Private Cases in Single Care	566

In addition to these there are under the Mental Deficiency Act :—

Certified Institutions	39
Certified Institutions (under Sect. 37 of the Mental Deficiency Act)	37
Certified Houses	9
Approved Houses	21

In all, there were contained in these institutions in 1918 in the United Kingdom 142,000 persons of unsound mind, including 566 cases in single care, and 5,000 imbeciles. According to the Fifth Annual Report of the Board of Control (1919), there were in England and Wales alone, in 1919, 116,703 notified insane persons. This number is less than that recorded a year previously by 9,138. There has been a notable decrease in the total number of insane in England and Wales for the four complete years of the war, this decrease being no less than 23,763. Against this, however, must be set the fact that there were on January 1, 1919, between 3,000 and 4,000 mental and nervous cases in military hospitals, of whom a large number will eventually be certified insane. The Commissioners are careful to point out, moreover, that practically the whole of this apparent decrease in the four years of the war is due to the abnormal death-rate among the insane in public asylums during the same period, which amounted in 1917–1918 to an increase of 17,293 deaths in excess of the

[1] The number was reduced during the war, several asylums being taken over as military hospitals.

average ratio for the decade preceding the war. The importance of this fact will be seen when we come to examine the question of the food supply, the shortage of doctors and attendants, and the compulsory economy in upkeep of public asylums caused by the war. We shall find that while the war was undoubtedly largely responsible for the greater recorded mortality among asylum patients, the causes of such an untoward increase were always latent in the defects of asylum management, and might have been prevented to a large extent had these defects been recognized and their results foreseen and provided against. All the war did, as I hope to prove in the course of this book, was to emphasize and exaggerate defects which were already in existence, but which were never recognized.

CHAPTER II

THE PROBLEM OF INSANITY

BEFORE proceeding to the main thesis of this book, viz., the study of the conditions of existence of pauper lunatics in our large public asylums, it may not be out of place, and may fitly introduce to the non-medical reader the question of asylum treatment, if I make a few general observations on the problem of insanity, and the objects towards which our treatment of it should be directed.

It may be stated, as a preliminary to this inquiry, that however much we may conceal our ignorance by learned phraseology, we know little more concerning the real nature of insanity at the present day than was known to the ancient Greeks and Romans. It is well that we should keep this fact constantly in mind, as it has important bearings on the question of treatment, and explains much of the apathy and indifference shown not only by the public, but by the medical profession itself, to all efforts directed at asylum reform, as well as much of the confusion that exists as regards our legal and moral responsibility to the insane. I am aware, of course, that this confession of ignorance will be strenuously denied by most physiologists and neurologists, and by not a few psychologists and alienists. In support of their contention they will point to the undoubted fact that we know a vast deal more of the structure and function of the brain and nervous system than was known to the Ancients, and that this knowledge is continuously on the increase, so much so, in fact, that were insanity

proved to be due to disease of the brain, we might justly regard ourselves as in a fair way to solve the problem. To most neurologists, indeed, for whom mind is a mere function of the brain, it may appear that the problem is already solved or in process of solution. Yet though the trend of modern physiological research and clinical investigation is undoubtedly in the direction of identifying disease of mind with disease of brain, it requires very little knowledge of the causal relationship between normal mind and brain to prove how little the conclusion is warranted. That this relationship is very intimate and far-reaching all psychologists, of course, admit. But until it is proved that normal mind is the result of the structure and function of normal brain, it is obviously premature to assume that abnormal mental processes are the result of cerebral disease alone, either functional or organic. That insanity is frequently associated with, and is often caused by, and, when long continued, invariably results in, gross lesions of cerebral tissue, is unquestionable, as we see in the familar instances of general paralysis of the insane, the cortical atrophies of senile and chronic dementia, as well as in advanced cases of delusional insanity and congenital idiocy and imbecility. But that insanity of various types, such as acute melancholia, acute mania, and epilepsy, can exist for considerable periods without any discoverable or appreciable cerebral lesion, seems equally certain. Undoubtedly the molecular and atomic structure of the cerebral cells composing the grey matter of the brain is of extreme complexity, but of the forces that maintain this structure in functional equilibrium during mental health we know nothing, and we are equally ignorant of the factors involved in its disturbance in mental disease. We cannot explore the brain-cells of a madman during an attack of acute mania or melancholia, and say whether they are or are not materially affected. The probability—nay, the certainty—is that they are; but if so, the fact that such serious mental maladies can be

recovered from without permanent ill-effects is evidence that the material injury is at times of a transient nature. Nor would the contrary fact, if proved, invalidate the contention that insanity is essentially a *disorder of mind* and not a disease of brain. Even in those cases, such as general paralysis of the insane, where disease of the brain is obviously the cause of the mental malady, the insanity consists in the mental malady, not in the disease of the brain. If we compare the brain as the organ of mind with a piano as an instrument of music, it is obvious that madness may result from one of two causes: either from disease of the brain rendering impossible the normal functioning of mind, or from disorder of mind interfering with the normal functioning of brain; just as disharmony in the playing of a piano may result from some mechanical defect of or injury to the piano, as well as from the incoherent strumming of an intoxicated musician. The result in both cases will be disharmony, but in the one case this will be owing to the imperfection of the instrument, in the other to the incapacity of the performer. And in insanity it is the result we are concerned with, that mental disharmony which we call madness, not the material brain-affection that is associated with it, either as cause, concomitant, or effect.

If madness, then, however caused, is essentially a *disorder of mind*, in what does this disorder consist? To ask this question is, as I said at the beginning of this chapter, to expose our ignorance, and to attempt to answer it would involve a psychological discussion far beyond the scope of this book or the qualifications of its author. It may be said, however, that our ignorance of what constitutes insanity is only part of our ignorance of what constitutes mind. Yet from the researches of modern psychology have lately emerged two facts which are of profound signification in this inquiry, the facts of dissociation of personality, and what is called the subconscious mind. Dissociation of the self, and the

phenomena of dual and even multiple personality, are matters familiar now to most educated people, and we have had in recent years a whole philosophy of the subconscious, and a new school of psychology, under the name of psycho-analysis, founded upon it by Freud and his disciples. Both these facts, however little understood, have let light into the "abysmal deeps of personality," and have lifted a corner of the veil that hides the profound problems concerned in normal and abnormal mentation. A study of them has at least gone far to assure us that the chief element in insanity is to be sought primarily in dissociation between the personality or self and the component faculties of the mind, such as emotion, intellect and will, and taking place mostly below the threshold of consciousness. The outstanding result of this dissociation is loss of conscious self-control, that is, control by the Self of his mental faculties, feelings or desires, which in their turn become disorganized and disconnected, and may even take on the aspect and play the part of separate personalities.

Without going further into this very interesting subject (for this is not a treatise on the psychology of insanity), I may say that this dissociation of personality is a familiar feature of dreams, and that nothing strikes the competent observer more than the remarkable resemblance between many of the phenomena of insanity and those of dreaming. In fact, the analogy between the dream-state and insanity is, in my opinion, far closer and deeper than most people, psychologists included, imagine. The mental state of the madman, indeed, may be described as a waking and disordered dream, and it is in the taking of this dream for reality that his madness chiefly consists. Similarly, it is the waking from this dream which constitutes his recovery—a recovery which is always possible where the brain-cells subserving the higher mental faculties have not been irretrievably injured or destroyed, or where dissociation has not been too complete for self-control to

be restored. For it is the lack of self-unification, and the loss of control that accompanies it, that are the abiding features of all mental disorder.

Leaving now any further discussion of these psychological problems of insanity, let us ask ourselves how far they have a bearing upon the question of treatment. If loss of self-control is the most important element in insanity, what follows from this fact? Surely that our treatment should be directed above all things to re-establishing the control that has been lost as speedily as possible and by every means most conducive to that end. For this object confinement and restraint of some sort are in most cases obviously necessary, for during the period when self-control is in abeyance the patient may do himself or others an injury for which he is not responsible, and as a rule he will be unable to support himself or look after his private affairs. Asylums, then, there must be, but these, as the name imports, should be homes of refuge, or mental hospitals, not, as too often is the case now, mental prisons or houses of detention. But while confinement is obviously necessary, the greatest care should be taken to make it as little irksome and ostentatious as possible, and to combine it with well-thought-out and scientific methods of treatment, meanwhile interfering with the patient's liberty as little as possible. Tact, kindness, sympathy, patience are above all things required in the treatment of all the insane, for if the prevailing feature of insanity of every type is dissociation of the self and loss of self-control, to re-establish self-confidence and self-respect, and to eliminate as far as possible all sources of mental irritation and emotional conflict, will be one of the surest ways of restoring such loss and helping the patient to recovery. To treat the insane as if they were criminals, to herd them together in huge barrack-like asylums, to make them wear a distinctive and humiliating garb, to restrict their liberty as forcibly and ostentatiously as possible, to punish them

for faults for which they cannot justly be held responsible, is from the disciplinary point of view as irrational and unscientific as it is from the psychological point of view to mix all classes of the insane indiscriminately together with no attempt at classification, and careless of the bad effect some types have upon others, or from the medical point of view to purge and drug them while denying them such forms of exercise, amusement, and employment as would conduce most readily to their recovery. To crowd lunatics into asylums is worse than useless unless we have some recognized principles of treating them when once we have got them there. Merely to confine the insane is not to treat them, and certainly not to cure them, except by accident. It is to leave them to recover or not, just as may happen. But it is even more than this. It is in many cases to aggravate their condition, to manufacture, in the late Dr. Maudsley's striking words, "asylum-made lunatics." That many of the recoverable patients are, under the present system, made permanently insane is to my mind beyond question. What would be thought of us if we treated sick people in similar fashion, if we filled our hospital wards with broken legs and diseased lungs, and left them to get well or not as they could? Would not the public conscience be stirred? Yet this is what we too often do with the mentally sick. Most of the medical and remedial treatment given to pauper lunatics in our public asylums may be summed up in two words, drugging and purging, to which in war time was added a little discreet starvation. I shall have more to say on this subject later.

I have spoken of the psychological difficulty of defining insanity, but its legal definition is equally vague and unsatisfactory. In law, an insane person is a person of "unsound mind," which is about as useful and illuminating a definition as if we said an ugly person was one deficient in beauty. In both cases the standard of what constitutes sanity or beauty is left undetermined. As law,

however, does not concern itself with psychological problems, but chiefly with matters of conduct and the disposition and management of property, the practical legal definition of an insane person is that of one whose conduct is " dangerous to himself or others," or who is otherwise " incapable of managing his own affairs." So important in the eyes of the law is this question of conduct that the late Dr. Mercier, the eminent English alienist, in despair of arriving at a comprehensive psychological definition of mental disorder, insisted during thirty years of a strenuous intellectual and controversial life, that insanity is " primarily disorder of conduct," which, though true enough from the legal standpoint, is from the psychological standpoint entirely inadequate and misleading. I reiterate this point owing to the importance of its bearing upon treatment, and especially upon our asylum treatment of the insane. For, from the standpoint of treatment, what is of most importance is the psychological, not the legal, definition of insanity ; of insanity, that is, as a disorder of mind (using " mind " in the accepted though somewhat misleading sense as including the emotions and the will, as well as the intellect), and not as a disorder of conduct. As long as an insane person is under detention and restraint in an asylum his conduct is of not much importance to himself or the community; what is of importance is the state of his mind. Our ignorance of insanity, as a psychological state, has thus a very important bearing on the question of treatment, and should induce us to recognize that the routine treatment, or, rather, lack of treatment, carried out in most English public asylums may not be the best possible. Above all, this recognition of our ignorance should awaken us to the fact that we have in our public asylums an immense amount of psychological material for the scientific and dispassionate study of insane problems, material which at present is going almost entirely to waste through lack of official interest, the imposition upon medical

officers of totally unnecessary clerical work, the persistent undermanning and underpaying of the Medical Staff, the worship of red-tape, the apathy of the general public, and kindred obstacles and ineptitudes. At present, as I have already stated, it seems not to have entered the ordinary official mind in Great Britain that lunatic asylums should exist not merely for the safe and humane detention, but also for the remedial treatment, and, if possible, for the cure of insane persons. Abundant evidence will be forthcoming in the following pages that neglect of this elementary consideration was paramount in the asylums with which I was connected. Moreover, if remedial treatment and methods of attempted cure were considered part of a Medical Officer's duties, I can only say that, as far as I was concerned, I received no hint of the fact during the whole of my term of office. And, indeed, the whole system of asylum routine, as will be seen in the sequel, seems designed to defeat such an object had it ever existed. For such an object to be successful, individual study of each curable case is imperative, and opportunities for such study were in my experience practically non-existent. For one thing, there was not sufficient time, and such time as there was was so badly arranged that little advantage could be taken of it. I never had less than 350 to 400 patients under my immediate care during most of my term of office, and this number was sometimes doubled or trebled, and it was simply impossible to give them all individual attention, or even such of them as would have repaid it. There was always a mass of clerical work to be done, much augmented by the war; the filling up of endless forms and official returns; the keeping of half a dozen Case Books; the reading of innumerable patients' letters, both those written and received; the interviewing of visitors on five days of the week; the reception of new patients; besides the morning, afternoon, and evening rounds, the visits to the farm, the workshop, and the laundry; the prescription

of medicines, minor surgical operations, and emergency calls night and day. Had there even been time for the study of individual cases, there was no convenient place where such cases could be interviewed in private. It was impossible to interview patients properly in the wards and airing-courts, the noise and distraction were too great; and there was nowhere else. Besides, the Head Attendants were always supposed to accompany the Medical Officers on their rounds, and this rendered privacy impossible. I shall never forget the surprise, not to say consternation, of one of these officials when I suggested, in my early days of office, that I wished to interview a certain patient in private. He assured me that it couldn't be done, that it was against the rules. When I insisted, and had the patient brought into one of the private rooms, he kept the door open and remained outside all the time. He afterwards read me a respectful lecture on the absurdity of supposing that I could learn anything of value by interviewing an insane patient in private! The Superintendent discountenanced such a procedure; the permanent staff never did such a thing; I might expose myself to injury; there were not enough attendants as it was to look after all the patients, etc. In fact, so hopeless an obstacle did I find the asylum routine to any serious psychological study of insanity that I was forced to give up the attempt, and to confine my attention to such cases as were recoverable, and were gradually becoming fit for discharge. This became before long the most important part of my work, and one to which I look back with most satisfaction.

I have now given the reader a brief insight into some of the simpler problems of psychiatry, and have shown him their connection with questions of treatment and legal procedure. But a few words on the various types of insanity that are met with in asylums may not be out of place. Thus in the text books insanity is spoken of as maniacal, depressive, delusional, melancholic, paralytic, epileptic, etc.; as conduced to by certain physio-

logical conditions such as puberty, pregnancy, lactation, and old age; or as caused by various drugs such as alcohol and Indian hemp; or by certain specific infections, such as syphilis, gout, and lead-poisoning. The reader is doubtless also aware that there are certain types of congenital amentia, or mindlessness, of varying degrees, such as idiotcy and imbecility; that epilepsy is commonly, though as I believe often erroneously, included in the insanities; that senile dementia, or the mental decay of old age, as well as that which results from most forms of long-standing mental disease, is a form of insanity. All these insane types are familiar, by name at least, to most educated laymen. But these terms are mostly descriptive, not explanatory, they are a classification of symptoms, not a definition or explanation of insanity itself. Most of them, also, confuse the clinical fact that insanity is not only a disorder of the *mind*, regarded as the intellectual faculty, but a disorder of the emotional or passional nature (which in its primitive or instinctive aspects is not the same thing as the mind, and in the evolutionary scale appeared long antecedently to it), as well as a disorder of the moral sense, including the will, which appears latest of all, and is different from either. Thus we have types of *intellectual, emotional,* and *moral* insanity, which can all be distinguished from one another, and which may presumably exist independently of each other, though as a rule, of course, in various degrees of combination. In most cases it is the more highly evolved and later acquired faculties that are first affected, and as lack of self-control is the prominent feature of all forms of insanity, we shall not be surprised if the characteristic symptoms of idiopathic mental disorder should appear first in the higher regions of the mind and will, i.e. as a dissociation between the higher and lower faculties of the self, though disorder in the latter sphere may often be the more prominent. But this fact has already been alluded to.

In my next chapter I shall introduce the reader to the wards and general routine of an asylum. In this manner he may be able to form some opinion of the matters treated of in this book and of the questions to which they give rise. Some of these matters may seem at first sight to be trivial and not deserving of the stress I have laid upon them, but most of them are not trivial, and even those that may appear so are component parts of the picture of asylum life which it is the object of this book to portray and, if possible, to get remedied. None are without importance in their bearing on treatment, and on the responsibilities which are incurred by those who undertake the charge of the insane.

CHAPTER III

WARDS AND GENERAL ROUTINE

In my first chapter (page 31) I left a recently admitted pauper lunatic in the Reception Ward of one of our large County Asylums. In the present chapter I shall follow his fortunes further, and describe one of the many days which he is probably destined to pass within the walls of this institution.

In the asylum of which I am now speaking, the male Reception Ward is part of the newer block of buildings, and is well built and fairly comfortable. It is in the same block as the hospital, and that part of it in use contains a number of open beds, and six single rooms. Patients who are violently maniacal or noisy, or who have a bad record, or who for any other reason (such as parasitical affections, skin disease, venereal infection, etc.) require isolation, are put in the single rooms until such time as they are considered fit for the open ward. These single rooms are features of all the wards, and must be shortly described, as we shall hear a good deal about them later on. In the ward of which I speak they are none too strongly constructed rooms, with a floor area of about 9 feet by 12, and about 12 feet high. The floor is composed of wooden blocks, and none of the rooms are heated. Each contains a coir mattress laid upon the floor, but no bedstead. The bedding consists usually of coarse canvas rugs, though the better behaved patients are allowed blankets when necessary. As many refractory patients tear up their bedding, canvas rugs

are imperative in these cases. The doors are provided with an observation-aperture strongly glazed, and the rooms are lit in the daytime by a window placed high and opening for ventilation purposes. These windows are shuttered, and the shutters lock back when open. At night the rooms are lit by an electric light bracket over the door, protected by a sheet of wire gauze. The doors of these particular rooms are none too strong, and have been burst open before now by violent patients. The walls have also been scaled by active and agile occupants, who have squeezed themselves through the wire-protected aperture over the door, and thus effected their exit. But these have been very exceptional cases, and for most practical purposes the rooms are sufficiently strong. They are not provided with locks, but have an outside handle and drop latch, the latter being a concession to the Board of Control who disapprove of locked doors in single rooms, but which are just as effectually closed with an outside latch as with a lock.

To return now to our newly-admitted patient. We must premise that he has been classified as suffering from melancholia with suicidal tendencies, and that, after being detained for a few days in the Reception Ward, he has been removed from there, owing to pressure on the existing accommodation in this ward, and has been placed in one of the general male wards. This removal of a patient from the Reception Ward owing to limited accommodation, and often before he is fit, is commented on later, and will be seen to be one of the most serious defects in asylum organization which it is my object to expose. The general ward alluded to is a mixed ward (like all the others in this asylum) containing some ninety or a hundred patients of various types of the more demented class, and a few actively homicidal or suicidal, and is under the care of an experienced and responsible attendant, or Ward Charge as he is called, with three or four attendants under him. (This at least was the number during my term of office.)

For reasons of safety, our patient, who may be quite mild-mannered and inoffensive in appearance and behaviour so far, has been placed upon what is called the "SS," or *special suicidal* list, which means that he must never be let out of the attendants' sight night or day. Under this category he has also to be put "behind the table" when in the ward, i.e. his freedom of movement is absolutely curtailed; he is not allowed to walk about or mix with the other patients, but must sit behind the table and against the wall, where he can be more closely watched and restrained if necessary.

Of all forms of restraint this of being put "behind the table" is resented more than any other by patients of every degree and type of insanity, except those who are past all feeling of resentment whatsoever, and who are reduced mentally to the condition of brute beasts. The only possible excuse for the existence of this brutalizing form of restraint is such a paucity of attendants as renders effective supervision of dangerous patients otherwise unattainable. Consequently, had this mode of treatment been merely a war-time expedient necessitated by the dearth of attendants, its use would have been temporarily justified, however deplorable it might be for other reasons. But this was by no means the case. For many years before the war, and as far back as the memory of the oldest attendant extended (i.e. some thirty years), this "behind-the-table" treatment of unruly and refractory cases had been the routine method in this asylum, and from inquiries which I have made I fear the same practice is a familiar feature in most of our large English asylums. Not only is this treatment reserved for refractory and quarrelsome patients, it is used as a method of punishment for minor offences as well. I say advisedly "I fear," because in my judgment there is no form of restraint so utterly uncalled-for, and no "punishment" so deplorable in its effects upon most forms of insanity, as this. It is utterly uncalled-for, because were there a

sufficient number of attendants, or were the patients properly graded and classified, instead of all types being herded indiscriminately together, it would be totally unnecessary. It is simply an inhuman device to save attendants trouble, and to diminish their responsibility. At bottom, of course, it is the result of a desire to keep down expenses and save the ratepayers' pockets, and is but another instance of the callousness of the asylum authorities in all matters where the welfare of the patients is pitted against the cost to the ratepayers. As a form of "treatment," so-called, it is utterly barbarous and irrational, and as a "punishment" it is often vindictive, and always brutalizing and degrading. Let the reader try to picture the scene. Here, perhaps, are a dozen or more of the worst cases in the ward. Behind the table they sit all day with their backs to the wall, and only leave their place to satisfy the calls of nature. In front of them is an attendant always on duty. They have no amusement, no exercise, no employment. Many of them, indeed, are incapable of amusement or employment and only suffer from the confinement and want of exercise. But the majority suffer from the privation of all three. Yet not even for meals do they change their places or surroundings. The speech of these patients is often obscene and blasphemous, their habits quarrelsome and filthy, their persons dirty and malodorous. Probably the saddest spectacle seen on this earth in recent years has been provided by a Bolshevik jail, crowded with starving, tortured, and terrified human victims. Yet even more mentally depressing is the spectacle of a "behind-the-table" crowd of lunatics in the "refractory wards" of our public asylums. Bestialized, apathetic, mutinous, greedy, malevolent—often quarrelling fiercely with each other, at meal times snatching away each other's food, or spitting into each other's plates—they sit all day in their miserable corner, at once the most damning indictment and the most degrading example

of our "humane and scientific" treatment of the pauper lunatic.

We will return once more to our newly-admitted melancholic.

This man, it will be remembered, has been classified as "actively suicidal," which probably means that before admission he has tried to do away with himself. He is obviously suffering from profound melancholia, and as such is miserable, taciturn, and depressed, probably unable to sleep for more than an hour or two at a time, and with a distaste for food or for any company but his own. One would have supposed that the rational treatment of such a case would have been to place him in as restful surroundings as possible, or at all events to keep away from him such sights and sounds as might tend to aggravate his disorder. But the authorities of this asylum do not so regard their responsibilities, and have made no such provision for these cases. The man is "actively suicidal"; he is, in asylum classification, a "behind-the-table" case; so behind the table he goes. Again I ask the reader to picture in imagination the scene. Here is a patient newly admitted, strange to, and probably fearful of, his surroundings, haunted possibly by unseen terrors, a prey to dejection and remorse, and by way of helping him to recover his mental poise and emotional equilibrium he is put with a filthy and ribald crew of chronic lunatics "behind-the-table." Truly a marvellous way of "ministering to a mind diseased"; a most scientific method of "plucking out the memory of a rooted sorrow!" Of course, in a well-organized asylum, this patient would have been kept for weeks, possibly for months, in a Reception Ward, and then transferred to a bright, cheerful ward specially reserved for such cases. But they did not manage matters so in my experience. New patients were pouring in all the time, the accommodation in the Reception Ward was limited, one whole such ward was shut up for lack of attendants, so into the ward

alluded to, which was the only one available, our patient had to go, and take his chance of recovery there as best he might.

"But surely," the reader will exclaim, "the Medical Officer in charge of the ward is the responsible authority in the matter, and can send the patient into any ward, and order any treatment that he pleases. It is for him to say whether such and such a patient shall be placed 'behind-the-table' or not." In theory, no doubt, this is possible, but in practice it is far otherwise, especially if the Medical Superintendent leaves the matter entirely to the Assistant Medical Officers, and these latter have to make the best use they can of the available accommodation. In this particular asylum there was *no* special ward suitable for the reception of such a patient, for all the available wards were full of mixed cases herded together without any attempt at classification. To make the necessary re-arrangement would have meant reorganizing the whole asylum, and how was a mere locum tenens to do that? The Medical Officer, of course, had authority to put on or take off the "SS" list any patient he pleased, but he did it, in my experience, on his own responsibility, and if trouble arose he had to take the consequences. And what was the alternative? Here was a patient reported in his certificates and classified as "actively suicidal," which means that he had to be kept under constant observation, for the whole object in sending such a patient to an asylum is to prevent him from doing harm to himself. The only alternative to putting him "behind-the-table," at least in a mixed ward, would be to tell off an attendant to take personal charge of him, and this, with the ordinary number of attendants attached to each ward, would generally be out of the question. In war time it was simply impossible. Where a Superintendent exercised careful oversight and arranged the classification and ward-distribution of cases himself, things might be different, and he might even see the necessity of reorganizing

the asylum system to some purpose. It was hopeless in my experience, for a mere Medical Officer, and a locum tenens at that, to try to alter existing arrangements. The official duty expected of him was to obey the "God of things as they are," not of "things as they should be." The only place in the asylum in question for "active suicidals," who were well enough to be about, was "behind-the-table"; so "behind-the-table" our melancholic patient had to go. And there for the present we must leave him.

The preceding paragraph may seem to the reader to be a digression, but, if so, it is an intentional one. This book is an attempt to throw light upon our system of asylum treatment of the pauper lunatic, and, as such, no opportunity will be lost of making as many digressions as may present themselves, provided this object is attained. In reality, these "digressions" contain the criticism which is the main purport of the book. I can best throw into relief the defects of asylum administration by showing how hardly it presses in individual cases, for in this way my criticism, and the justification for it, will coincide. The one will supplement the other. I make no apology, then, for asking the reader to cast his eye round the ward I am at present introducing him to, and familiarize himself somewhat with its conditions. It is a fairly large-sized ward (but not nearly large enough for the hundred or more patients it contains), some 60 feet long by 30 feet wide, with two open fireplaces surrounded by steel guards, with wooden benches lining the walls, and containing two deal tables. There is a smaller side-room, containing a billiard-table, opening into the corridor outside; but this is usually regarded as forming part of the adjoining ward. A few oleographs are on the walls, and there is also a reading-stand with the morning papers. But there are no bookshelves, and not a book to be seen anywhere. The patients are not supposed to require books, which are looked upon rather as dangerous weapons

of offence, or handy missiles for the "glass-breaker," than as sources of recreation or mental diversion. Two sides of the room are practically all windows, but as these windows only look out into a featureless yard, and on to a gravel path, the view does not add much to the patients' enjoyment of life. The amount of glass in the whole asylum is remarkable, and gives endless opportunities for "glass-breaking" to those patients who are prone to this habit. On the floor above the ward are the dormitories, and opening out of it (i.e. on the ground floor) are the lavatories and bath-house. The ward is in charge of a special attendant, named a Ward Charge, with three or four attendants under him during the daytime, and three on duty at night. In general control over all the male wards are the three Head Attendants and the Night Head Attendant. These rank in authority next below the Resident Medical Staff, and most of the actual administration of the asylum is in their hands. The number of attendants in this ward, and in fact throughout the asylum, is utterly inadequate for the proper supervision and care of the patients contained in it, but during the war it was found impracticable and even impossible to add to them. But the proper proportion, viz., one attendant to ten patients, was, I am told, in marked abeyance in this asylum even before the war, as, I suspect, it was and is in abeyance in most of our County Asylums. I comment upon this fact elsewhere.

While the reader has been looking round the ward and taking stock of its features, he will have noticed the mixed character of its inmates. There are, to begin with, the twelve unhappy creatures "behind-the-table," among whom is our latest recruit. The rest are sitting about on the benches, or walking rapidly to and fro in the ward. Some are shouting and gesticulating, jostling and occasionally cursing their neighbours, a few are reading the papers, a few more are quietly conversing together. But the majority are sprawling on the benches, some lying,

some sitting, silent, moody, and sullen. One patient is rocking himself rhythmically from side to side in a stereotyped mechanical fashion which he may keep up for hours. He is a case of what is called in the text books "catatonic paranoia," or delusional insanity with stereotyped movements. There are numerous cases of these forms of "catatonia" in all asylums. There are two such cases in this ward at the moment. But the ward contains in fact a mixture of most forms of (non-acute) insanity. Here are the victims of fixed "delusions," the commonest of all forms of insanity, and one that accounts for an eighth part of all inmates of asylums; the victims of auditory and visual "hallucinations," who "hear voices," and "see visions," and who may be at times violently homicidal or suicidal, or again quite well behaved, and, except for their particular "delusion," quiet and rational members of the community. You may talk with such an one for an hour or more, and except you approach the subject of his delusion, might never know that he was insane. These are the cases that so puzzle the lay visitor to lunatic asylums, who is apt to wonder where all the insane people have got to. Yet these subjects of delusional insanity, for all their appearance of sanity and good behaviour, are among the most dangerous class of lunatics. They are often very cunning besides, and will conceal a delusion which they have learnt may get them into trouble with the authorities, till an opportunity arises for its expression, when homicide may be the result. Here, again, are cases of incipient general paralysis of the insane, that fell disease, due always to syphilitic infection, which attacks men chiefly in the prime of life, and often in the plenitude of strength and intellectual power, but which sooner or later, and usually within four or five years, has a fatal termination. Mixed with these are to be seen cases of confusional insanity, melancholia, dementia in all its forms, a dozen or more epileptics, and a sprinkling of imbeciles or congenital mental defectives. In fact, except

for the absence of those suffering from acute mania, the general paralytics who are in too advanced a stage of illness to be up and about, and the senile dements who form so large a proportion of all asylum populations, most forms of insanity, except of the most violent and unruly type, are represented in this ward, and even some of the latter are not wanting. It is not a pleasing spectacle, though one gets used to it in time, as one gets used to much that is wearisome and even repulsive when it is part of one's daily work. The danger is that one may get so used to it that one's sympathies become blunted, and one's clearness of vision clouded by custom. But to the thoughtful and sympathetic observer, who is not inured to the spectacle, it gives food for much and varied reflection. He no longer wonders at the attitude of chronic pessimism which characterizes asylum doctors, attendants, and patients alike; the profound melancholy and dreary hopelessness which impregnates like a miasma the general asylum atmosphere, and which presses so heavily upon all those who live within its walls. He even understands the apathy and indifference which is so prone to attack those who year in and year out have the medical charge of the unhappy inmates, and whose lives are spent in the seemingly hopeless task of trying to ameliorate their condition. He understands, I say, but he cannot condone. Further reflection only too surely convinces him that many of the evils he sees around him are remediable, and are due not so much to the intractableness and hopelessness of the malady, as to the callousness and stupidity of our treatment of it. Madness, indeed, is one of the saddest and most mysterious of human afflictions, but if taken sufficiently early and treated sympathetically and rationally, it is not one of the most incurable. And its psychological interest is no less than its moral appeal. Not only does the effort for its relief appeal to all that is most unselfish and ennobling in human nature, its study, from the psychological and sociological standpoint, is of

enthralling interest; for the key to some of the profoundest problems of life and mind lies here. It was the utterly irrational system of treatment, if such an absolute *laissez-faire* routine can be described as treatment at all, carried out in the asylums in which I worked, and the almost entire official neglect of the mass of psychological material presented for study and organized research, which made the life of a Medical Officer in these institutions so profoundly depressing and disheartening. But there is no inherent necessity for many of the evils I am describing. The provision of more doctors and attendants; the lessening of the mass of clerical work at present imposed upon the Medical Officers; the proper classification and ward-distribution of the various types of insanity; the provision of special blocks for incipient cases; the isolation of epileptic patients; these and a score of other reforms which it is the purpose of this book to bring before the reader would make life in a lunatic asylum a much more cheerful and endurable thing than it is now, and would hold out hopes of cure which are at present utterly unrealizable.

The question of the admission of epileptics into asylums is a very difficult one. No hard and fast line, in my opinion, can be taken on the matter; each case must be decided on its own merits. Many epileptics are dangerous lunatics, and for such a lunatic asylum is obviously the proper place. Many are not insane at all, in the psychological sense of the word, though as they are usually not responsible for their actions for some time immediately before or after an attack, they are at such times insane in the legal sense. And most epileptics tend to become mentally irresponsible in the course of years if there is no abatement in the fits, owing to progressive degeneration of the brain. A good number completely recover, and of those who do not, a certain proportion live useful lives and are able, with proper supervision, to go about their ordinary affairs. It is

presumed, of course, that all epileptics admitted into asylums are insane, and they must be so certified on their certificates, but though the majority show insane symptoms, there is little doubt that a considerable number even of those admitted into asylums are not proper subjects for detention in such institutions, and have been mistakenly certified as insane. There were at least three in my wards during my term of office who in my judgment were mentally responsible, two of whom I was instrumental in discharging. But whether insane or not, there is no question that epileptics in asylums should never be allowed to mix with other patients, but should have a ward to themselves. The effect of the terrifying sights and sounds that accompany an epileptic attack, especially at night, upon early mental and highly nervous cases can be easily imagined, and is frequently deplorable. Though not all epileptics are legally insane, it is necessary for most of them to be under restraint of some sort, and, if paupers, preferably in special "colonies," of which there are far too few in this country, where many of the slighter cases can be usefully employed and may lead fairly happy and contented lives.

It is time now to return to the melancholic patient whose experiences we are recording. The hour has come for the occupants of the ward to have their morning exercise in the airing-court, where we will now follow them. The signal is given by the Ward Charge, and by twos at a time the patients are passed out of the ward under the supervision of one of the Head Attendants, who must always be present both when the patients go out and when they come in. This particular airing-court is one of the best and largest on the male side of the asylum, as indeed it ought to be, seeing it is the only exercise-ground for the inmates of three wards, which between them contain some three hundred or more patients. It consists of a strip of grass surrounded by an asphalt walk, and shut

in on the north and west side by a roofed but otherwise open corridor. The corridor on the west side is barricaded or barred on its open front. The airing-court is perhaps half an acre in extent, and is not closely railed in and enclosed like the other airing-courts on the male side, but gives access on the south to another grass plot. There are wooden benches in the corridors, and in front of the west side. Four warders or attendants are usually in charge of the 150 or more patients who are taking exercise, though in pre-war times there may have been double the number. Not all the patients from the three wards mentioned above are in the court, for a large number of those in Ward 6 (the "Working Ward") are sufficiently trustworthy to be employed in the various asylum industries; a few from each ward are working in the wards or dining-hall, and a certain number are confined in the single rooms in Ward 8 for disciplinary or punitive reasons, while a few are ill in hospital. It is a cold, foggy December day, of which in this part of England we get a great many in winter time. It is raining, too, and the general outlook and surroundings are gloomy and depressing. The patients are all dressed in the regulation asylum garb, which consists of a fustian coat and waistcoat and white drill trousers, with a neckcloth, and in some cases a cap. The ex-service patients are dressed in Government tweed suits, to distinguish them from the others, and to mark the appreciation of a grateful country for their war services. All wear heavy, ill-fitting asylum-made boots. But though it is raining fairly heavily none of the patients wear overcoats, nor, indeed, do the attendants either. In both cases it is against the regulations, though in very bad weather macintosh capes are sometimes worn by the latter.

As there may not be a more fitting opportunity for referring to this subject of the asylum garb, it is necessary now to deal with it. Few things are more deeply resented by the ordinary pauper lunatic and his friends than the

depriving him of his own clothes, and the compulsory wearing of what he and they regard as "prison" attire. It is well to speak strongly, for I feel strongly, on this matter. There is no possible justification, legal or other, for such an indignity, and there is every moral and personal reason against it. Nothing is so destructive to an insane patient's self-respect as his deprivation of his own clothes, and it must be remembered that we are dealing with a patient, and a mental patient, not with a criminal. We medical men are very indignant, and justly so, that the public should be encouraged in the opinion, totally unjustified and detrimental as it is, that insanity conveys a social and personal "stigma" upon an insane patient or his relatives, for we know how greatly such a mistaken feeling militates against the early, and for this reason most likely to be successful, treatment of insanity, by tending to make the relatives of the insane, educated and uneducated alike, conceal the first symptoms of mental disease occurring amongst their families from their medical attendant. We inveigh against this "superstition" in our text books, and at meetings of our medical societies, and deplore the wording and application of legislative Acts which seem to support this connotation. And yet here are asylum authorities doing all in their power to justify and intensify it. I am persuaded that nothing tends more to promote the conviction among pauper lunatics and their friends that madness is regarded by the Law, and Society generally, as a crime and disgrace; as certainly nothing tends more to promote the "prison-feeling" among the patients themselves than this compulsion to wear a distinctive and humiliating garb. Many lunatics have complained bitterly to me on the subject, and said that it made them feel like convicts "all but the broad arrows." I repeat that to force a pauper lunatic to wear what to him is "prison dress" is nothing short of a scandal, and should immediately be put an end to. I am ignorant as to how far this custom is usual in British asylums, though from

Dr. Weatherly's strong remarks in his recent book, *A Plea for the Insane,* I gather that it is fairly general. And the Government themselves, by their provision of a suit of ordinary clothes to all ex-service patients, tacitly acknowledge the fact that a distinctive asylum garb may justly be regarded as conveying a social stigma. But not only is the compulsory wearing of such a garb legally unjustifiable, it has no practical arguments in its favour. The only arguments that can be considered such are that it is economical, and that it enables escaped lunatics to be more easily recognized. As regards the first contention, that surely is the patient's concern ; as to the second, the answer is that the dress, while distinctive *within* the asylum, is not distinctive enough *outside* it. Everyone can recognize the " broad arrows " on an escaped convict's prison clothes ; but hardly anyone would jump to the conclusion that a man wandering about in a fustian jacket and white slop trousers was an escaped lunatic. He might quite well be an ordinary British workman. If the option of wearing these clothes were given to the patients, the asylum authorities would soon find out what the lunatics themselves thought about it. In Dr. Weatherly's forcible words, " May it please God to see this wrong righted. I can find no excuse for it." Neither can I, only I should invoke public opinion instead of the Deity.

One result of this compulsory wearing of asylum garb has been noted above. Most male pauper lunatics, however poor their circumstances, are the possessors of an overcoat, and in our climate the value of such an article of apparel is not to be lightly estimated. But the asylum authorities, while depriving the pauper lunatic of his overcoat, when he has one, do not provide him with a substitute. The consequence is that in wet and cold weather the unhappy patients, with health already undermined by their malady in many cases, and by the coarse and innutritious food supplied in most asylums, suffer

grievously in winter time. Should they get wet while at exercise, as they often do, they have no change of clothes, and little chance of drying those they have on. I shall be told, no doubt, that this is a trivial matter, and that paupers are used to getting their clothes wet without suffering any bad consequences. But I have yet to learn that, when this occurs, paupers have to sit in their wet clothes all day for lack of others to change into. I shall be told, again, that the present complaint I am making is not relevant, that it is the duty of the Medical Officer to see that asylum patients do not get wet, or at all events that they do not take exercise in wet weather. In theory, of course, this is no doubt true, like so much else that is said in extenuation of asylum administration, but in practice it is really negligible. I have myself often given orders that the patients are not to be taken into the airing-courts in wet weather, and when it is raining heavily these orders are carried out. But it often starts raining when they are already out, and in these cases, if it does not rain heavily, they are generally kept out for the allotted time, because they are always supposed to take shelter. But in practice not many of them do this, and as a consequence many come in wet through. Had they overcoats to wear, and take off, not much harm would be done. As they have none, what usually happens is that in winter there is a great increase of entirely preventable bronchial and rheumatic affections, with permanent ill-health often resulting, and occasionally deaths from pneumonia, etc. Tuberculosis, in particular, is a deadly scourge in most asylums. In 1915 the asylum death-rate from this disease was 16·1 per 1,000, while the mortality for the same year among the general population was only 1·6 per 1,000. And though exposure to wet and cold, and improper diet, do not of themselves produce consumption, they are the most potent accessory factors in its production among those predisposed to it. The same holds good of that dreadful scourge influenza.

During the recent pandemic of this virulent and infectious disease (October-December, 1918) eighty deaths occurred from this cause in this asylum alone. In their Fifth Annual Report (1918) the Board of Control comment on the greatly increased death-rate in public asylums for the year in question, the increase of deaths from influenza and tuberculosis alone amounting to 1,217 and 1,021 respectively, and observe that "the exceptionally high death-rate for tuberculosis in a few asylums is especially noticeable." I wonder if it has ever occurred to these learned gentlemen to connect this excessive mortality with the facts of deficient clothing and defective feeding, in addition to the imperfect isolation, and the want of proper consumptive wards, to which they mainly refer it?

Meanwhile, what has happened to the patient in whom we are interested? He has come out into the airing-court with the rest, but he is not among those who are walking round the quadrangle. I alluded in a previous paragraph to the enclosed corridor which ran round two sides of the quadrangle, and remarked that that on the west side was barred on its open front. The object of this is now evident: it is to provide an enclosed space or pen in which those patients who are on the "SS" (special suicidal) list, or any that are refractory and are thought likely to give trouble, can take exercise. It is, in fact, the airing-court duplicate of the "behind-the-table" treatment in the ward, and is reserved for the same class of patients. There, crouched against the wall, with hanging head and drooping shoulders, we meet again the latest addition to the ranks of the pauper insane, adding further to his asylum experiences, and wondering in his miserable soul what crime he has committed worthy of such treatment—for that he is being "punished" he has no doubt. And, indeed, it is not easy to tell him if we tried, for we have no satisfactory answer ourselves. We should have to admit that, even if insanity is no crime, in the eyes of most asylum authorities it is precious

like one, or at all events is to be treated as such. I have not yet decided which is the worse or more degrading treatment, to sit "behind-the-table" all day without moving, or to take one's exercise like a wild animal in a pen. I confess that it needs a good deal of philosophic detachment to hold the balance evenly between the two.

In front of the "pen" paces an attendant on constant guard, at the corner stands another equally watchful. For the pen holds some bad characters, and there are constant altercations and at times some free fights among them. Not only does it contain the "behind-the-table" patients previously alluded to, but there are perhaps a score of other patients besides, some released for exercise from the single rooms (or "cells," as the patients call them), where they have been incarcerated for some asylum offence or other, or because they are quarrelsome and unruly, and need special watching. The Medical Officer on duty, of course, has the authority to say who shall be kept in the "pen" or not, and can liberate anyone at any time if he thinks fit. But it is essential for disciplinary purposes to give the Head Attendants some latitude in the matter, though not all of them can be trusted not to abuse their powers. After all, the attendants see much more of the patients than the doctors do, they are with them day and night, and should know best who are to be trusted and who not. And it is an unwritten rule in this asylum that all patients who are upon the "special list" must take their exercise in the "pen," for otherwise they cannot be sufficiently closely watched. A patient cannot come out of the exercise "pen" without being *ipso facto* and automatically taken off the "special list." Still, for all that, it behoves a Medical Officer to keep his eyes open, for it sometimes happens that out of spite, or in retaliation for some supposed affront, a Head Attendant may put a patient in the "pen" or "behind-the-table" without adequate cause. Patients can be very

exasperating at times, and even Head Attendants are human.

But whatever the rules and usages of particular asylums, the fact remains that for the existence of such abominations as the exercise "pen" and "behind-the-table" there is not the shadow of excuse or justification. They are not only brutal and degrading forms of restraint, which do infinitely more harm than good, they are at the same time a cynical expression of the real, but unacknowledged, official view of what asylum treatment chiefly exists for. This view is that asylums exist to detain and restrain demented paupers, never, except accidentally, to treat and, where possible, cure them. The whole system of pauper asylum administration in this country, though there may be exceptions in the case of individual asylums, disguise it or deny it as we may, exists for no other purpose. Detention and restraint, as cheap and effective as possible, sum it up. And cheapness is the key-note. I would beg of the reader not to go away with the impression that war-time economies are chiefly responsible for these evils. They existed long before the war, and unless public opinion intervenes, will exist for long after it. The war has made them more prominent, but that is all. The question of cost is the deciding factor in the matter—that, and the purblind ignorance and indifference of officialism. We all know that Englishmen are conservative and unimaginative, but we like to think that they are humane. We loathed the unspeakable inhumanity of the Germans in the war, but in the matter of treatment of their insane poor the Germans are much more humane than we are. It is no use blinking the unpleasant fact. Nothing can be more inhumane than the treatment which I have described, as nothing can be more irrational and unscientific. Why not make the frank, if brutal, confession that we do these things because they are cheap? For that is what it comes to at bottom. If the Asylum Committees were com-

pelled by law to employ a fixed proportion of attendants to patients (the proportion being somewhat higher in the refractory wards, but estimated by Dr. Mercier for the whole asylum as one to ten), if asylums were rationally constructed and arranged, and the patients properly sifted and classified, the supposed necessity for such brutal ineptitudes as the "exercise-pen" and "behind-the-table" treatment would not exist. For the only apparent "necessity" in the matter is the supposed necessity of saving the ratepayers' pockets. Fully granting the fact that discipline must be upheld, and that disciplinary forms of restraint, and even punishment, are occasionally necessary in public asylums, I unhesitatingly deny that these particular forms of restraint and punishment are necessary. Were similar treatment meted out to pauper patients in our hospitals and infirmaries, there would be a public outcry. To treat *sick* paupers as criminals, to make them wear a distinctive garb, to deny them proper treatment and to stint them in medicines and surgical appliances because of their cost, to withhold from them the best medical and surgical skill, in a word to *punish* them for being sick, would excite the severest public censure. Yet what are insane paupers but the *mentally sick*? Why should these be punished any more than those? why should they be degraded, ill-clothed, stinted of nourishing food and medical comforts, exposed to humiliations and insults, because they are mentally, but not physically, sick, though they are often both? I know of no reason. As I shall have something to say in a future chapter of the dearth of hospital equipment, of the abuse of powerful drugs, of the lack of surgical and especially nursing skill, of the entire absence of special dental and ophthalmic treatment, and many kindred matters, I shall for the present say no more upon this subject, but return to the patients' daily routine.

As I walk round the quadrangle, with one of the Head Attendants and a Ward Charge at my side, a few of the

patients say "Good morning," but the majority pass by without any greeting. I enter into conversation with as many of them as possible, for this is one of their few opportunities of speaking with the Medical Officer. But not many patients take advantage of it, though a few make complaints; and as "discharging day" comes round, a certain number press the Medical Officer to take their cases into consideration. As a rule, those who do so are least fit for discharge. A few make angry observations, and even threatening gestures, but these patients are pretty well known to the attendants, and as a rule no Medical Officer, who has not made himself personally unpopular, is exposed to any danger of personal injury. Few complaints, as I say, are made by patients (at least that was my experience), chiefly for the reason that the attendants are always close at hand, and most patients, especially the older ones, regard the attendants as their real masters, as, indeed, they mostly are, and on this account consider that to make complaints in their presence is a mere waste of time. This feeling is natural and not to be avoided, but I always did my best to overcome it, and took a patient aside whenever he wished to say anything to me in private. I myself regard it as imperative to the proper treatment of insanity that facilities for private interviews with patients should be provided in all asylums, for it is essential that no avoidable feelings of injustice should be allowed to rankle in their minds; and, besides, no proper individual study of insane cases is possible without the opportunity of private interviews, as I have stated elsewhere. But asylum authorities seem strangely blind to this fact.

In the course of my rounds I hand out the letters which have come for the patients in my charge this morning, and which by order of the Superintendent I have previously read. It is a rule in all asylums that all letters, either sent or received by patients, must be read by the Medical Officers. This is obviously necessary in the case of those

written by the patients, for many of these are too insane or obscene to be sent. It is as well at times to send letters written by patients to their friends, however insane and ridiculous their contents, for in this way the recipients are kept informed of the writer's state of mind, and thus realize the necessity for his detention, a necessity that many relatives are often ready to question, and occasionally violently to deny.

There is one exception to this rule of the opening and reading of the letters written by patients which must be alluded to, for it shows an apparent desire on the part of the Legislature to safeguard the patients' interests, which in theory is highly commendable, but which in practice is almost entirely nullified. It is laid down in the Lunacy Act of 1890 (Sect. 41) that "The manager of every institution for lunatics shall forward unopened all letters written by any patient and addressed to the Lord Chancellor, or any Judge in Lunacy, or to a Secretary of State, or to the Commissioners or any Commissioner, or to the person who signed the order for the reception of the lunatic, or on whose petition such an order was made, or to the Chancery Visitors or any Chancery Visitor, or to the Visiting Committees of any institution in which such lunatic is detained," etc. Also, that a printed notice of this order, "whenever the Commissioners so direct," shall be "posted up in every institution for lunatics, *unless there is no private patient therein*" (Sect. 42). The first part of this provision is undoubtedly wise and necessary, yet it is completely nullified by the second part which limits its publication to the discretion of the Commissioners, and only to those parts of public asylums *which contain private* (*i.e. paying*) *patients.* The consequence is that not one pauper patient in a hundred is aware that such a legal provision is in existence. What is the use of such a public safeguard, if those for whose benefit it exists are kept in complete ignorance of it? Thus, while apparently giving with one hand, the Legislature takes away with

the other. Why only private patients should have the benefit of this knowledge I fail to see, and this is only one more instance of the many anomalies and futilities of the present Lunacy Act. The law, of course, is strictly observed, though whether anything ever comes of it when a patient takes advantage of this privilege is open to doubt. A question was asked in the House of Commons upon this point in May, 1890, and the then Secretary of State (Mr. Matthews) replied that letters so received were never read by himself, but were always handed to the Commissioners, who took any action that was necessary. What particular use there is in a lunatic writing to the Home Secretary, if the latter merely passes on to the Lunacy Commissioners the letters received under this provision of the Act, does not transpire. Why not state at once that all such letters must be addressed to the Board of Control, and have done with it? To grant the apparent privilege of an appeal to the Home Secretary presumes the intervention of an impartial and disinterested tribunal, but this turns out, after all, to be only an empty formality. And yet in the interests of the inmates of lunatic asylums such an impartial and duly authorized tribunal is badly needed. Shall we ever get it?

The reasons for the opening and reading of all letters *received* by lunatics are chiefly two. The first reason is that such letters may contain money, and pauper lunatics are not allowed to have the use of money. If one asks why, the answer usually given is that it puts temptation in the attendants' way, by which is implied that the attendants may cozen weak-minded and demented patients out of this money, or that patients may bribe attendants with it to recommend them for discharge or even help them to escape. But as there is no way of preventing patients receiving money from their friends on visiting days, though this is not strictly allowed, and as many patients do thus receive money, this particular answer does not carry much weight. As a matter of

fact patients *are* allowed to have pocket-money, only this money must be held by the Head Attendant or Ward Charge, and spent for the owners on such luxuries and extra delicacies as are permitted them. And as regards the bribing of the attendants, what is to prevent the patients' friends from bribing them as it is ? It is quite possible that many attendants, even Head Attendants, are bribed by the patients' friends, and that some make quite a tidy little income in this way. The patients believe, and with perfect justice, that the attendants have great power in their hands, and many opportunities for befriending them, such as giving them extra helpings at meal times, gifts of tobacco, little privileges in the wards, and even the power of helping forward their discharge by keeping their names prominently before the Medical Officers, etc. And if the judicious expenditure of a little money will help to bring any of these desirable things about, it is not to be wondered at that patients and their friends will take this way of ingratiating themselves with the attendants. But for an attendant to take bribes is another matter altogether, and deserves, and usually receives, the severest penalty. In fact, an attendant who is discovered taking bribes from patients or visitors is generally discharged on the spot, and with perfect justice.

So that if it is on the chance of their containing money that all letters addressed to patients have to be read by the Medical Staff, there does not seem much to be gained by the practice. No patient can *spend* money except by making use of an attendant or a visitor, and this is allowed as it is. Why not trust them, then, to hand over to the Ward Charge any money that the letters may contain ? I am persuaded that the trust would seldom be abused, and in fact that the more you show patients that they are worthy of trust, the more readily will they respond. Asylum authorities, of course, are far from believing this ; the principle they act upon is just the

opposite. I shall have more to say on this question when I refer to the subject of putting patients on *parole*. Of one thing there is no doubt. All patients in asylums resent having the letters they receive opened and read before they receive them. I think they resent it more than having the letters they write read, for they can, in a sense, appreciate the reason for the latter rule. The second reason for opening letters received by patients is that they may contain incentives to, or provide facilities for, escape from the asylum. That this contingency is theoretically possible there is no doubt, and for this reason there is justification for the practice, though from an experience of reading thousands of such letters I have come across no instance where such an attempt was made. Still, while there is such a possibility, the letters must be read, though the duty is an unpleasant and irksome one, and disliked by Medical Officers as much as by the patients.

While on the subject of patients' letters, it is necessary to refer to a crying need in all public asylums, and that is the provision of patients' letter-boxes in all the wards. These boxes should be locked, and the keys of them kept by the Medical Officers, *not* by the attendants. Much as the patients dislike their letters being read by the doctors, they resent the fact of the attendants reading them still more. There were no letter-boxes in the asylum from which most of the facts detailed in this chapter were taken, and I was particularly struck by the eagerness of most patients to hand over their letters to me instead of giving them to the attendants. After all, it is only natural. The attendants see more of the patients than anyone else, and are apt to be very curious about their family matters and affairs generally, of which they may make subsequent use to the patients' disadvantage, for many of the attendants live in the neighbourhood, and are known to the patients' friends. There are often matters connected with a patient's past which he does not care to become common knowledge. Such privacy should be

respected. This is only one of the little things, but it is one of the things that count.

One bad result of the attendants reading the patients' letters is that it tends to give them power over the patients which they should not possess, and to confirm the patients in the opinion, which is also shared by the attendants, that the attendants are their real masters, not the doctors. And such a feeling does not conduce to the disciplinary health and good administration of the asylum. I am not saying that such a feeling is not unavoidable in the administration of all public institutions. I imagine that most convicts feel that their jailers are more important persons than the Governor, the Chaplain, or the Doctor of the jail, as in fact from the convicts' point of view they are ; just as the permanent officials of a great Government department consider themselves, and often with justice, much more important persons than the Secretary of State. And of attendants in asylums this is especially true. None the less, I maintain it is most important to the effective discipline of an asylum that the spheres of duty and activity of the Medical Staff and the attendants should be strictly delimited. The attendants are far too prone as it is to take upon themselves duties which strictly appertain to the Medical Officers, and to save themselves trouble, the latter often wink at, or even encourage, this transference of responsibility. The patients are quick to perceive the fact, and in consequence often show more respect for the attendants than they do for the doctors. The latter, of course, are to blame for not more effectually asserting their authority. I knew a Medical Officer who never sent up a patient for discharge without seeking the approval, I had almost said the permission, of the Head Attendant. Is it to be wondered at that these officials sometimes, in popular parlance, "get above themselves" when treated in this fashion? Many Medical Officers, also, to save themselves the trouble of reading the letters written by patients, ask the attend-

ants to read them first, and mark the envelopes of those which in their opinion ought not to be sent. This, again, is a very undesirable practice, and should be strictly discountenanced. It not only shuts off from the Medical Officers a very important source of information as to the mental state of the writers, but it puts too much power in the attendants' hands, and gives the patients the feeling that their private affairs are being unnecessarily pried into, and that their defenceless position is being taken advantage of. This is above all things to be avoided. The duties of the attendants are very onerous and responsible, but reading the patients' letters should not be included among them. And the only way to prevent this is to have locked letter-boxes for patients in all the wards.

The above has been another digression from the account of my morning round of inspection, but the reader will now see its purport. By giving him a clear impression of the daily routine of the pauper lunatic's life, he will see where the shoe of asylum administration pinches. For, like the asylum boots which the patients have to wear, it pinches often and painfully. The attendants (and often, one suspects, the permanent Medical Staff) are so used to these things that they never notice them, or, if they do, think them unavoidable. So many things we are used to seem unavoidable and hardly worth the trouble of altering, especially if they do not affect our own comfort. But if one tries to put oneself in the patient's place, and thus change the angle of one's mental vision, it is astonishing how differently things appear. It is almost like the acquisition of another sense, the "altruistic sense," one might call it. And we all know how difficult that is to acquire.

To return once more to the airing-court, which I am now leaving to make my bi-weekly visits to the farm, workshops, and laundry. As I go out I pass once more before the "exercise-pen." Two of the patients have been fighting, and one has got a bloody nose and a cut lip.

He is the aggressor, and has got the worst of it, as he usually does. As I come up he calls out, " Doctor, doctor, why don't you put me out of my misery? You know I've got to die; why don't you kill me at once?" Poor creature! he is indeed a repulsive object. Dirty, degraded, dishevelled, with blood-shot eyes and a bestialized expression, even the miserable crowd by whom he is surrounded seem to shrink from him with contempt and loathing. His delusion is that he is doomed to death, and that he must fight everyone round him in order to prevent it. In a properly constituted asylum he would not be allowed to mix at large with the other patients, but would have an attendant detailed off to take charge of him while at exercise. But the attendants in this asylum are far too few in number for detailed duties of this kind, and he has to take his chance with the rest. To protect him from himself, and to avoid constant fights and quarrels, I tried at first the plan of keeping him isolated for days, and sometimes for weeks, in a single room, but he was always as bad again as soon as he came out. Obviously he could not be kept indefinitely in the pitch-dark and evil-smelling "cell" that is called euphemistically a "single room," for his health was breaking fast under confinement, and he was becoming more insane every day. Yet it was difficult to know what else to do with him. In this dilemma I consulted the Superintendent, explaining the case and my difficulty in treating it. The difficulty really consisted, as the reader will have perceived, in the paucity of attendants, and the miserable alternative of confinement in the only available single rooms in the ward. "How long," I asked, "do you approve of such a case being kept in a single room? He has already been there three weeks, and I am afraid of his breaking up altogether if I keep him longer." "You need not be in the least afraid," he answered; "keep him there for three months if necessary. I have kept similar cases for three and six months in a single room

when I was Medical Officer. Of course he must be taken out for an hour's exercise every day, and walked up and down between two attendants, and then put back in his room. He won't come to any harm." A conscientious Superintendent would, of course, have interviewed such a case himself, and preferably in consultation with his assistant. As it was, the cynicism of such an answer was only equalled by its apparent indifference to the demands of the intelligent treatment of the insane. I ventured to suggest that we could not possibly spare two attendants to look after one man. There were only four attendants on duty in the airing-court at that time to look after some 150 patients, many of whom were unruly and not to be trusted. But the Superintendent merely reiterated his injunction. I consulted the Head Attendant, who said flatly that it could not be done, the attendants couldn't be spared without even graver risks being run. If the Superintendent gave the order, of course, it must be obeyed, but he declined all responsibility for the results. Sooner than create an impossible situation, and bearing in mind the exigencies of war time, yet utterly disapproving of the policy of continuous isolation for such a case, I took the matter into my own hands. I was determined not to confine the patient any longer if I could help it, and preferred to take the risk of his getting knocked about a bit outside, sooner than of his being slowly tortured to death or hopeless dementia in the "cells." I took the man aside and explained matters to him as well as I could. He was sensible enough at times, and promised to do his best if I wouldn't lock him up. His best wasn't much, as we had evidence just now, but it was a long way better than the horror of solitary confinement in a pitch-dark cell. But the question of solitary confinement, and, indeed, the whole question of what is called "mechanical restraint" in asylums, is so important that it requires separate consideration, and will be dealt with in the next chapter.

CHAPTER IV

MECHANICAL RESTRAINT

I HAVE already, in a previous chapter, described the "single rooms" in the Reception Ward, and need not take up the reader's time by a second description. They were a prominent feature of all the wards in this asylum, except the "working" ward, the single rooms of which contained beds, and were far more comfortable. Each other ward contained six or more of these single rooms or "cells," as the patients called them. It is all very well to see these rooms in daylight, as the Commissioners do on their annual visit of inspection, which possibly accounts for the fact that they never comment adversely upon them in their Reports. For then the door and windows are open, the latter are unshuttered, the floor has been scrubbed and disinfected (!) with Izal, and the atmosphere is fairly fresh and redolent of antiseptic. But the rooms are never like this when occupied by patients. The window, it is true, may possibly be open at the top, but the door is shut and latched, the shutters are closed and locked, no light and very little fresh air enters (none at all if the window is closed, as it usually is in winter), and the atmosphere soon becomes foul. The stench at times is so great that I have been unable to remain in the room more than a few minutes. Let the reader imagine, if he can, the existence of an inmate of one of these rooms, in almost pitch darkness night and day, clad only in a canvas shirt, lying on a thinly-stuffed and noisome coir mattress spread on the floor, and

covered with two or three dirty canvas rugs, with a permanent draught blowing under the door (this is anything but *fresh* air), and if in winter time, with the temperature possibly several degrees below freezing-point ; for most of the cells are not heated (none of them, in fact, in the male wards of the asylum referred to, except those in the hospital), and only those in proximity to the ward fire-place have any heat in the daytime, and none at all at night. Imagine such an one haunted by " voices," and terrified possibly by horrible " visions," unable often to sleep, and not seldom in bodily pain from some injury or internal trouble, the atmosphere reeking from the contents of the rubber chamber-utensil, or from the excrement which he has smeared upon the walls and floor of the cell, and even upon his own person, for this is by no means uncommon in maniacal and demented cases. Can the reader be surprised that the place often gives its occupant the horrors, and that he does his best to escape from it ? Is it any wonder that patients confined in these rooms often rave and blaspheme, and hammer on the doors with naked feet and hands in their fruitless efforts to get out ? Not that these efforts are always fruitless. The doors are not often burst open, they are too strong for that, though once or twice even this has been done in an access of maniacal fury. None the less, the patients manage occasionally to free themselves, and in my own experience three patients at least have escaped from these cells. One, a sailor, with no foot or hand-hold that would have supported a cat, jumped up the bare walls to the wire-covered aperture over the door, tore down the wire-netting, and squeezed himself through the opening. Another, an Irish stevedore, a powerfully built man and six feet high, got out of the adjoining cell in the same way. In the remaining case the panels of the door were broken and the latch loosed. These facts tell their own tale.

We talk of the horrors of Bedlam, where raving maniacs

were chained naked to iron staples in the walls of filthy cellars, and bedded on straw, while the public were admitted at so much a head to gloat over their ravings; but is such a cell as I have described such a *very great* improvement upon Bedlam? Anyhow, is it the sort of place in which the reader would like anyone belonging to him, who was smitten with the pitiable malady of insanity, and to the cost of whose keep he was possibly contributing, to be confined for days, and possibly weeks and months at a time? And yet not once, but many times, I have seen a private patient, who had been well educated and brought up (not that that makes much difference), and to whose maintenance his friends were contributing a guinea a week, confined in one of these cells for weeks at a time, and by my own orders. I could not help myself; the man was "seeing red" and dangerous, and, in default of other and more rational means of treatment, *had* to be confined, for his own sake and that of others; there was nothing else to be done with him. That was the disgraceful part of the whole business: *there was nothing else to be done with him.* Some strong rooms there must be in every asylum for violent and dangerous cases, though I am aware that a few Medical Superintendents, such as Professor G. Robertson, late Superintendent of Morningside Asylum, Edinburgh, to whose wise and humane initiative Scottish asylums owe so much, have for years done without them, and found that they were not really required for even the worst cases, if there was the proper number of attendants available to look after them; but that is the crux of the whole question. But where single rooms are in use, they should at least be warmed and properly lighted and ventilated, and have some similitude to the habitations of human beings, instead of resembling rather the lairs of wild beasts. And the Board of Control's recommendation as to locked doors should be strictly enforced, instead of being evaded in the daytime, and an attendant told off to watch these patients day

and night, *whatever the cost to the asylum.* The cost! It all comes back to that, and to the powers placed in the hands of the Visiting Committees, and by them delegated to the Medical Superintendent. What do the members of these Committees care for the welfare of the unhappy lunatics for whom they are responsible, so long as they can keep down the working expenses, and show a lower maintenance-bill than neighbouring asylums? They might conceivably care if they knew, but how many of them have personally investigated the condition of these cells *when in occupation*, or made surprise visits to the wards? Yet for what purpose have they been appointed *Visiting* Committees? I can only speak from my own experience, but in the course of nearly two years I never met a member of the Visiting Committee in any of my wards in either asylum. I would beg the reader not to take away the impression that the picture given in this description has been in any way exaggerated or overdrawn. It is a cold, uncoloured statement of hard, everyday fact, and its accuracy can be vouched for by any past or present Medical Officer of the asylum in question, or, for the matter of that, of probably any other public asylum in this country.

I shall be asked, of course, what the Board of Control was doing to allow the existence of such a state of things. The Commissioners visit the asylums in the United Kingdom every year, and their sole duty is to inspect and report. I always smile when I think of the official visits of these gentlemen which I was privileged to witness, as I always smile, though somewhat cynically, when I read their Asylum Reports. I shall never forget my first experience of one of these events. I had not been in office more than a couple of months, and a visit of the Commissioners was shortly due. But no one knew exactly when to expect it, as the greatest secrecy is observed at Headquarters about these matters. They are supposed to be surprise visits, but, owing to some

mysterious telepathy that exists between asylums, they seldom are. An hour or two's warning is generally forthcoming, nobody exactly knows how, and that is enough. I was walking through one of the corridors on the morning in question, with my thoughts far away from any Commissioners. Suddenly an unusual stir was apparent everywhere, and word went round that "they" were coming. Instantly all was bustle and confusion. I met attendants hurrying through the corridors carrying bundles of blankets and bed-clothes. It appeared that there were not the proper number of blankets on many of the beds, and the Commissioners were very particular about bed-clothes. The single rooms were at once emptied of their occupants, who were all hurriedly dressed and sent into the wards. I was new to the business, and asked why. I was told that it was a standing order of the Superintendent's, from which I implied that there were matters connected with the occupancy of these rooms which it was better the Commissioners should not know. The rooms were then hastily scrubbed out, disinfected, and ventilated. They needed it badly. As a rule, they are only scrubbed out when they have been fouled by some particularly filthy occupant, though that may happen once or twice a week. At last, after two hours' strenuous work, things were fairly shipshape; the patients were all up, dressed, and congregated in their respective wards; every attendant was at his post; and the Medical Officers were busily refreshing their memories as to such salient facts as the number of patients in each ward, the number of attendants, the number of epileptics, patients in hospital, etc. The asylum, in fact, *was ready for the Commissioners*; and not long afterwards these two gentlemen arrived. I was curious to see them, for they are very potent beings in the asylum world, and were always spoken of by the attendants with awe and bated breath. Not so by the Medical Superintendent, who, though compelled by etiquette to be present on these

occasions, showed by his attitude that he regarded the whole business as a farce, and no little of a bore. And for once I was disposed to agree with him.

As the reader has already been told, the Visiting Commissioners are two in number, one a doctor, the other a lawyer. The doctor on this occasion had been, I was told, a former Asylum Superintendent himself, and "knew the ropes"; the lawyer was an old gentleman, in appearance not far short of seventy, who was somewhat feeble in his gait, and said little, possibly because he thought a great deal. But what his thoughts were, of course, I could not discover. The inspection began.

Ward after ward was rapidly visited; single rooms, newly scrubbed and freshly ventilated, were peeped into; locked doors were opened; ward-cupboards made to give up their secrets; bathroom taps, window-hasps, and door-handles were solemnly investigated; searching questions were asked embarrassed attendants as to dirty-linen baskets; the number of patients and attendants in each ward was carefully noted in pocket books; the Commissioners addressed remarks and questions to a few patients, and a few patients (a very few) addressed remarks, not always complimentary, to the Commissioners. The usual number of hopelessly insane patients pressed for their immediate discharge; the usual number of patients with real grievances, which they knew too much to mention, sat gloomily silent. It was an interesting and impressive scene. The hurried and blasé Commissioners; the bored and indifferent Superintendent; the constrained and anxious attendants; the composed and critical lunatics, who realized well enough that the whole drama was staged for their especial benefit, and were not disposed to applaud the performance; the self-conscious and flustered nurses—all made up a varied picture which engraved itself upon the memory, and was instructive and amusing to look back upon.

It was my duty to go round the wards with the

Medical Commissioner, but realizing probably that I was merely an elderly locum tenens, and could not be expected to know much about insanity, he asked me few questions. Why should he? He had been a Medical Superintendent himself, and no doubt had his own views about the proper treatment of lunatics. The persons most interested, and far the most impressed, were the Head Attendants. This was natural enough, for they knew by experience that if any fault was found, it was usually with themselves, and they looked upon this annual inspection as more a test of their characters and efficiency than as an examination into the efficiency of asylum administration, in its bearing on the comfort and welfare of the patients. And I have no doubt they were right.

The inspection lasted a day and a half, and on the surface was fairly thorough. The various wards, and the male and female hospitals, were visited in the morning of the first day; the farm, workshops, laundry, etc., and the annexe, containing over a thousand additional patients, in the afternoon. After that, presumably, the Case Books were examined, for not to make the requisite number and kind of entries in the Case Books may be a misdemeanour and punishable as such, and the law is very particular in these matters. Not that the examination could have been anything but perfunctory, for, as we shall see later on, the keeping of these Case Books is very much of a farce as at present conducted. The next morning other parts of the asylum were visited, such as the offices, store-rooms, kitchens, etc., and an inspection was made of the dining-halls during the dinner hour. One courageous Commissioner, I forget which, even tasted the soup served to the male patients, and remarked, with rather a wry face, that it was "very good, very good indeed." "Have some more, old cock," ejaculated *sotto voce* a jocular lunatic hard by. Possibly the cook had excelled herself on this occasion, in contradiction to other occasions, about which I shall have more to say in another chapter.

The visit was a hurried one, for it was war time, and the Commissioners were much overworked. In pre-war times, I was told, these visits sometimes lasted three or four days, as well they might, for an asylum containing three thousand patients needs some inspecting. In the afternoon the Commissioners left, and the asylum, with a sigh of relief, a "Thank goodness, that's over" sort of feeling, subsided once more into its humdrum and non-inspected condition. The Report, which we were enabled to read the same evening, was quite satisfactory, and even flattering on the whole. A few faults were found, as there were in duty bound to be—who ever heard of an inspection where no faults were found?—but they were chiefly faults of omission, and in the opinion of the Head Attendants, the recognized asylum critics on these occasions, were not highly incriminating. Some dust had been discovered under an emergency-exit door; an unlabelled draught of bromide had been found in a ward-cupboard; one of the bathroom thermometers was out of order. All these were noted, and the unlabelled bottle severely animadverted upon in the Report.

But on the matters to which I have ventured to call attention in this book the Commissioners were strangely silent, probably because they were too polite to mention them, possibly because they were so used to them that they regarded them as of little importance. The whole Report was summed up to his entire satisfaction by one of the Head Attendants in conversation with me the next day. It was an excellent Report, he said to me: not a single patient had made any complaint against an attendant!

I hope the reader will not take away the impression from this account of an annual inspection that the Board of Control is a body of inefficient and tradition-bound officials, who receive large salaries, and take little interest in their duties. This is far from being a true picture, at least in recent years. The present Board contains members of

acknowledged medical standing, some of the latter, such as Dr. Clarke Bond, whose work upon the Board has been of great value, being mental specialists of large experience and deservedly high reputation. Taken on the whole, they are no doubt a well-informed, conscientious and deserving public body, who are by no means overpaid, and who are certainly very much overworked. It is the constitution and sphere of action of the Board that is its chief defect. Nor is the custom of appointing to its ranks retired Medical Superintendents of asylums to be encouraged. Most of these men have grown old in administering the very system which is in such urgent need of reform. New blood and wide vision are needed upon a Board charged with such responsibility and powers, and possibly new methods of election to its body. I am unaware what the present methods are, but probably, as obtains in so many Government departments, the appointments, like kissing, "go by favour." The members of this Board, as Dr. Weatherly justly observes, have many difficulties to contend with, not the least of which is that they have to administer an Act with many of the provisions of which they are in profound disagreement, and to the anomalies of which they have often called attention. It is a very difficult position, and one to which I shall refer more fully in the chapter devoted to Legal Reforms. Here I need only say that the chief administrative defects of the Board appear to me to be that it is overworked, that it contains too few members of marked administrative ability, and that its centralization in London adds largely to its expenses, while putting it out of touch with the provinces.

To return once more to the question of solitary confinement, which we were discussing when the visit of the Commissioners interrupted us. In my opinion, though I grant my experience is not large, far too much reliance is placed upon the isolation treatment or "seclusion,"

as it is technically termed, of certain forms of lunacy in British asylums. It is my profound conviction that in most cases this treatment does far more harm than good, and should be avoided whenever possible. All patients with whom I have spoken on the subject have expressed to me their horror of isolation, especially under such conditions as I have described, and which obtain, probably in most English asylums, as they certainly did in the two asylums in which I served. Cases of acute mania, of course, require to be isolated, but these should always be, and usually are, treated in the hospital wards. Destructive, dangerous, and very dirty patients also require isolation often over considerable periods, but these should always be treated in special wards reserved for such cases, and not allowed to mix with the other patients. But though they are isolated, they need not necessarily, except in rare cases, be confined in locked cells. Most violent patients can be placated and reasoned with, and most dirty patients, who are not utterly demented, can be taught good habits. It is simply a question of tact, kindness and patience. This is where the argument of those who advocate female nursing for male patients comes in, as has been so signally shown by Professor G. Robertson in Scotland. It has been found that the most refractory male patients are often more amenable to discipline at the hands of a female than of a male attendant. At bottom, presumably, it is a question of sex-attraction. But, whether male or female attendants are employed, a sufficient number should always be on duty to obviate the necessity of locked rooms, except in the most violent and dangerous cases. And in these cases an attendant should always be on duty outside the rooms day and night. This would obviate much of that horror of loneliness and darkness from which confined patients usually suffer, and which, I am persuaded, so often interferes with their recovery, and even increases their mental disorder. As

to whether padded rooms should be provided for violent patients, expert opinion is divided. I agree with the late Dr. Mercier that they are mostly unnecessary, except in the hospital wards, where one or two such rooms are essential for weak and elderly patients, who are liable to fall and knock themselves about. The chief drawback to padded rooms is the difficulty of keeping them clean and sanitary.

But whatever its necessity as a precautionary measure, all isolation of patients for punitive purposes should be sternly prohibited, even when offences are committed. Such a habit as "glass-breaking," for instance, is, in most cases, a disease; it is often a phase of "claustrophobia," or fear of shut-in places, and is really an involuntary reaction against confinement in all its forms, which all lunatics, and prisoners of every kind, are liable to; and to "punish" such a nervous reaction by still closer confinement is not only inhuman, it is illogical. What a "glass-breaker" needs is, as a rule, more liberty, not more restraint. A game of football, or work in the garden, if they are young or intelligent enough for either, is the best cure for such patients, not solitary confinement in a dark and noisome cell. That is far more likely to exaggerate than to cure their propensity. Yet there are Superintendents, apparently, and certainly many attendants, who never realize this simple fact; and what Superintendents do not realize, mere Medical Officers are mostly unable to carry out. Over and over again during my term of office I had to consent to such patients being "isolated" against my better judgment. But what could one do? From my previous experience, it seemed hopeless to apply to the Superintendent; there were far too few attendants for the individual supervision of such cases; and discipline, especially with such a depleted staff as existed in war time, had to be maintained. Had the isolation-rooms been decently lighted and warmed, it would not have been quite so bad, for

light and warmth are companionable things, and are even some slight compensation for the loss of liberty. But the single rooms in my wards were all that such rooms ought *not* to be, and it went against all my professional and personal instincts to confine a patient in them longer and more often than I could possibly help.

Yet in no single Report of the Board of Control that I have read were these rooms ever adversely commented upon. The only explanation that I could come to was that they were no worse than the single rooms in most other asylums.

A word is necessary here as to the legal aspect of this question of isolation or " seclusion." According to Regulation 86 of the Mental Deficiency Act, the definition of " seclusion," which I presume applies to lunatics as well as mental defectives, is " the enforced isolation of a patient between the hours of 7 a.m. and 7 p.m., by the closing by any means whatsoever of the door of the room in which the patient is." Nothing is said about the *night*, by which it appears that, technically, " seclusion " can only take place in the daytime, and that to lock a patient up at night is not to " seclude " him. It is, of course, necessary to fasten the doors of all single rooms occupied by patients at night-time, and in the case of patients who are not technically " secluded," and are fairly sane, this is no hardship. But in the case of " secluded " patients, it is just as terrifying for them to be locked in at night as it is in the day, and possibly more. There is no doubt that such patients should always be slept in the open wards where possible, or, if they must be in locked rooms, that the attendants should have special orders to keep them under constant observation. For this reason the number of night-attendants should be doubled, if necessary. But the fact that " seclusion " is legally impossible at night causes this necessity to be mostly ignored. I only know that in

my experience, when all the single rooms were occupied by "secluded" patients, there were never any extra attendants on night duty.[1]

It is also laid down in the Lunacy Acts (1890–91) that all cases of "*seclusion*" must be "at once recorded" (Sect. 13), and a copy of all entries of "mechanical restraint" be sent by the Medical Superintendent to the Board of Control every quarter. Failure to comply with either of these regulations is a "misdemeanour" (Sect. 40). Whatever may have been the case in other asylums, I regret to say that this regulation, at least as regards "seclusion," was, in my experience and during my term of office, more honoured in the breach than the observance. I myself, during my first year of office, omitted scores of times to enter cases of "seclusion" in the Case Books. The reason was that I was entirely ignorant of the regulations, and no one had ever drawn my attention to it. The Superintendent, when I was first appointed, never informed me about any regulations, or gave me any instructions whatsoever. Though entirely new to the work, we locum tenentes were supposed to find out all these things, and most others, for ourselves. Even when I knew of the regulation, I am sorry to say I often forgot to conform with it. And it never made any difference; it never does. No one ever looks at the Case Books, except the Medical Officers and, I presume, the Commissioners, and occasionally, perhaps, the Superintendent. The Visiting Commissioners may glance at them once a year, but they can't find out from the Case Books the existence of an entry that ought to have been there, but

[1] If, as is understood and contended in this book, "seclusion" is legally included among "the means of mechanical restraint," the Act enforces this continuous supervision. It lays down in Rule 4 that these cases are to be "*kept under continuous special supervision by an attendant, and under no circumstances are to be unattended.*" (*Fry on Lunacy*, p. 710.) This disposes of the matter.

wasn't. They could only find this out by a long and searching inquiry and examination, and what Commissioners have time for that? And even if every case of "seclusion" were entered in the Case Books, no one would be any the wiser. No records of such cases were ever made out, to my knowledge, or included in the list sent up to the Commissioners every quarter. It was different with cases of so-called "mechanical restraint." There was a special register kept of these cases, which had to be initialled monthly by the Medical Officers, and a list of these *was* sent up every quarter. But nobody ever bothered about "seclusions"—they were far too common. And I suspect this is the case in most public asylums. Yet the law exists, and the law is openly ignored, as it always will be in such cases, when there is no practical means of enforcing it. The only way to prevent by law the abuse of locked rooms would be to make their use *for any reason whatever* illegal; and this, of course, would be absolutely impracticable, according to our present ideas of treating lunatics. And, indeed, it is hard to see how asylum treatment of the insane could be conducted without the means of enforced seclusion when necessary.

But it is quite possible to make "seclusion" as a *punishment* illegal, and it is high time this was done. In fact, "*punishment*," as far as patients are concerned, *and in the physical sense,* is a term which we should banish once for all from our asylum vocabulary. For punishment is not the same thing as discipline, though no attendants, and, I suspect, few Superintendents, will ever be got to see it. Discipline there must be in every asylum, and discipline when necessary must be enforced. But it should be by moral persuasion rather than by mechanical means. Where moral persuasion fails, more material methods may be tried, such as the deprivation or curtailment of certain privileges, much prized by inmates of asylums, e.g. the privilege of smoking, of sitting up an

extra hour in the evening, of playing games, attending concerts and dances and the like. All these methods of enforcing discipline, or forms of "moral restraint," as they might be called, are infinitely preferable to physical coercion, and as a rule far more efficacious. And they do no injury to health, either material or mental, which physical coercion, especially in the form of solitary confinement, undoubtedly does. But, as I say, few of those in actual charge of lunatics realize the essential difference between punishment and discipline. The first thing an attendant, male or female, thinks of when a patient "breaks out," as it is called, is to "punish" him, and some Medical Officers even will support this view. Yet in very many cases it is not the patient, but his malady, that is responsible. In such cases it is as rational to punish a mental patient for refractory behaviour as it would be to punish a typhoid fever case for a rise of temperature. And of other cases of refractoriness a certain proportion are likely to be due to some ineptitude of asylum administration, or to some injustice or petty tyranny on the part of an attendant. I don't mean to say for a moment that many patients do not offend deliberately, or that most lunatics do not know the difference between right and wrong. They undoubtedly do, and it is a wrong inference from this established fact which constitutes the injustice in many cases of the celebrated "McNaughton ruling." But a knowledge of right and wrong is not the same thing as the power to put it into practice. When insane persons do what they know to be wrong, they mostly do it not because they are deficient in knowledge, but because they are deficient in self-control. As I have said before, lack of self-control is the very essence of insanity. Such patients act upon an uncontrollable impulse, and *can't help what they do.* But it is difficult to get attendants to see this, almost as difficult as it is to get some Judges. Because sane persons have the power of self-control when they are

annoyed or injured, such persons are apt to assume that lunatics must have it. But this is just what most lunatics lack. The very definition of a lunatic, at law, is one "who is not responsible for his actions." If he were responsible, and his actions were punishable, he would not be in an asylum, but in a jail. Take once more such an action as "glass-breaking." This, which is perhaps the commonest of all asylum offences, is, in the eyes of the attendants, one of the most heinous. Why? Because it is a means by which a patient may do himself serious injury, or even commit suicide? Partly, no doubt; but chiefly because an attendant for this very reason is most likely to be charged with neglect, and get himself into trouble. It is *the injury to themselves* that most attendants are thinking of, much more than the possible injury to the patient. For patients may not only commit suicide by this means, they may even escape, and in either case the attendants are likely to get into serious trouble. That is what in their eyes constitutes the heinousness of the offence. And that is why, though they would never admit it, they are so convinced of the patient's responsibility for his action. It is an action for which *they* may suffer, so he *must* be responsible. Personally, I don't suppose an attendant really cares twopence if a lunatic commits suicide or escapes, provided the blame for either cannot be brought home to himself; but if he was on duty at the time, then the attempted escape or suicide, even if it has not been successful, is a "crime," and to be "punished" as such. Of such, though in a minor degree, is "glass-breaking." As I have stated above, glass-breaking is, in my opinion, due in most cases either to a species of asylum "claustrophobia," or to an irresistible impulse caused by intense irritability and nervous repression, the result of a general feeling of the injustice of his confinement, or of resentment against the tyranny, actual or imagined, of an attendant. In some cases, of course, it is due to rage, revenge, spite,

or mere "devilry." In any case, it must obviously be suppressed, for it is a dangerous habit and one likely to become infectious, and the wilful perpetrators of it must be brought to see that it does not "pay." There are plenty of ways of teaching them this besides the common way of locking them up. And "glass-breaking," being a well known and common asylum affection, asylum authorities should put as little opportunity of breaking glass in the patients' way as possible, by having no glass in unnecessary places, and protecting all indispensable lower windows with wire netting. And "glass-breakers," being well known, should be collected together in a properly protected ward. Yet what do we find? I have alluded before to the fact that in the asylum of which I am speaking the sides of whole wards were nothing but sheets of unprotected glass, and that many of the wards were more like glass-houses than proper tenements for insane patients. To a patient with glass-breaking proclivities such an expanse of assailable windows was an almost irresistible attraction, the glass positively *asked* to be broken. It almost looked as if the asylum architects had been in league with the glass manufacturers, and were determined that this industry at least should not shrink in value. If "glass-breakers" did not already exist as a definite insane species, this asylum would have gone far to create it. I often pointed this out to the Head Attendants, but it was all to no purpose; I could not uproot their deep-seated conviction that "glass-breaking" was a lunatic's form of original sin. It was in vain to argue the Gospel precept, "Needs be that offences come, but woe to that man by whom the offence cometh," and to point out that if "opportunity makes the thief," unprotected glass, and plenty of it, in a lunatic asylum makes a "glass-breaker." They would have none of it. They were not responsible for the glass, but they could get the glass-breaker punished, if possible, and punished he usually was, though I set my face against

all avoidable "punishment by seclusion."[1] No doubt they were in a difficult position. For one thing they had custom on their side, if not reason or justice, and custom in an asylum, as I soon found out, goes farther than either. And since glass in war time was very expensive, and the authorities would not go to the expense of protecting it, and the asylum obviously could not be rebuilt, and since, too, an epidemic of glass-breaking was not to be encouraged in the existing dearth of attendants, custom had to be deferred to, and reason and justice, not for the first time, went by the board. This was only another instance of the official blindness and ignorance that characterize so much asylum construction and government. That many evils exist asylum authorities could probably be brought to admit; but as they were not responsible for their inception, they appear to think that they are not responsible for their continuance, especially if any change involves a serious outlay of the ratepayers' money. Once more it is a question of cost!

While on the subject of "mechanical restraint," of which "seclusion" is, in my reading of the Act, legally a part, I cannot refrain from drawing the reader's attention to the anomalies of the existing Lunacy Act in reference to this question, for nothing more aptly illustrates its policy of "straining out a gnat and swallowing a camel." We have seen how the Act, in the matter of seclusion, is practically a dead letter, owing to the impracticability of enforcing the entries of "seclusion" in the Case Books, or the indifference of the Medical Superintendent or the Commissioners in carrying out its provisions. We have seen, too, how the objections of the Board of Control to the use of locked rooms in the daytime, except in

[1] While defining what is meant by "seclusion," there is nothing in the Act which I can find which provides that for such seclusion a medical order is necessary. The general practice seems to be that the Head Attendant on duty reports the "seclusion" to the Medical Officer, who is thus technically responsible for it.

urgent cases, are evaded by using outside latches and handles in the place of locks. We have now to see how the Act interprets and provides for other means of "mechanical restraint." These are defined by Rule 4 as "including all instruments and appliances whereby the free movements of the body or any of the limbs of a lunatic are restrained or impeded." Thus defined, "seclusion" in a locked room can hardly be called "mechanical restraint," for the "freedom of the limbs and free movements of the body" are not thereby interfered with. But there seems no reason to doubt that the intention of the Act is to include "seclusion" in the definition of "mechanical restraint," and Dr. Stoddart so includes it (*Mind and its Disorders*, 3rd Edition, p. 531), though the wording of the Act leaves much to be desired. As to the other kinds of "mechanical restraint" permitted, which interfere with the free movement of the limbs, such as strait-waistcoats, gloves, covered baths, sheets or towels fastened at the sides of the bed, etc., the Act is very specific and particular in its provisions, and these can only be lawfully carried out under the conditions there laid down. All records of these cases, as I have before stated, must at once be entered in the Case Books and a list of them supplied to the Commissioners every quarter. The *spirit* of these regulations is excellent, as is also the very salutary insistence by the Commissioners upon the fact that all forms of "mechanical restraint," even those legally permissible, "should always be restricted within the narrowest possible limits, should not be long continued without intermission, and should be dispensed with immediately they have effected the purpose for which they were employed" (*Fry on Lunacy*, p. 711, 4th Edition). How far such a ruling is compatible with keeping a patient in a pitch-dark, locked-up cell for three months at a stretch, even with the allowance of an hour's daily exercise, I leave to the intelligence of the reader.

But though the *intention* of the Act in this matter is humane and salutary enough, observe its result in action. A patient, let us say, suffering from general paralysis of the insane is bedridden in hospital. He is helpless, and, what is worse, he is liable to constant "fits." In these fits he frequently falls out of bed, and such is the brittleness of the bones in this most distressing malady, that this accident may result in the fracture of one or more of his limbs. It would seem eminently humane, and in accordance with the dictates of common sense, to keep such a patient from falling out of bed by the application of a roller towel fastened to the bed on each side. But that is "mechanical restraint," and can only be lawfully employed if an attendant is told off to keep the patient under "continuous special supervision." In other words, the condition attached to its use makes the employment of this form of restraint unnecessary, for if the attendant has continuously to supervise the patient, he can himself prevent him from falling out of bed without using the roller-towel. Thus the condition attached to it defeats one of the main objects of this particular form of restraint, which is to prevent the patient from hurting himself without necessitating the constant presence of an attendant. The same argument applies to the use of the "gloves" (special gloves that cannot be removed by the wearer). The condition attached to these particular kinds of restraint is, moreover, usually quite unnecessary. These paralytic patients are not violent or dangerous, they are weak, paralysed, practically helpless people, and always in this stage of their illness hospital cases. In fact, they often form the majority of the cases in the male hospital wards, and are far too numerous to be bedded on the floor in the single rooms, which, besides, are generally occupied by excited noisy cases. The practical consequence, in my experience, was that, as special attendants could not be spared for them, these paralysed patients were usually left without any form of restraint, mechanical

or other, with the result that they sometimes fell out of bed and hurt themselves. This is an instance of what I think may justly be called "straining out a gnat and swallowing a camel." Once more, the intention of the law is excellent, but here again it defeats its own object. There is, of course, a danger in some cases of leaving "mechanically restrained" patients unattended, as in the use of the "strait-waistcoat" and "covered baths," but the supervision of an attendant in the previously mentioned cases could well be left to the discretion of the Medical Officer.

I remember being called hurriedly to the hospital one evening. A general paralytic patient had fallen out of bed and broken his leg. There was only one attendant on duty in the ward at the time, and he was otherwise engaged, and could not help the accident happening. As I went through one of the wards on my way to the hospital I passed a single room in which a refractory patient was "secluded." It was after 7 p.m., and no attendant was within call. The patient was beating on the door with his fists and feet, and was shrieking out curses and imprecations. "For God's sake let me out, doctor! for God's sake let me out! O Christ, they are killing me! for God's sake let me out!" As I came back, after setting the broken leg, the same horrible sounds greeted my ears. They would probably continue for hours, keeping everyone in the vicinity awake, and ultimately might necessitate my giving the man a hyperdermic injection. My reflections were not pleasant.

Here was one case in which a little harmless, though illegal, "mechanical restraint" would have prevented a serious injury. Here was another where a different but legal form of the same restraint was causing extreme misery, and possibly serious harm. The application of a roller-towel would have prevented the first patient from injuring himself, while the neighbourhood of an attendant would in all probability have mitigated, if it did not

entirely prevent, the sufferings of the other. In neither case was the proper treatment forthcoming. In both cases the patients suffered, in the first case from a literal compliance with an imperfectly considered law, in the second from a misinterpretation of an obscurely worded one. In both cases the law was technically obeyed, and in both cases this obedience did more harm than good.[1]

The only other forms of restraint applicable to insane patients in asylums are "manual" and "medicinal." "Manual restraint" means the restraint of violent patients by physical force. This is a thoroughly vicious form of restraint, though for some unexplained reason the Board of Control seem to regard it with more favour than "mechanical restraint." It is difficult to understand why. Manual restraint always means, as Dr. Weatherly states in the book already quoted from, "a continuous fight and struggle between patient and attendant," and has the further drawback that it cannot be regulated, and may involve the loss of temper and patience on the part of those applying it. It is a human and variable instrument, and correspondingly unreliable, and it is liable to be abused. My own opinion, and those of most asylum Medical Officers, is that it is a far less satisfactory form of restraint than the mechanical. It certainly requires more care and discretion in its use.

"Medicinal," or "chemical" restraint is restraint by means of drugs, which are chiefly sedatives, like morphia, opium, hyoscine, bromide, etc., hypnotics, like chloral, sulphonal, and paraldehyde, and the more powerful purgatives, like croton-oil. These must now be considered at length.

In the regulation of this form of restraint the law,

[1] The whole point of the above criticism depends, as the reader will see, upon whether the intention of the Act was to include "seclusion" among the forms of "mechanical restraint," and, if so, whether the provisions relative to such restraint were intended to apply at night-time.

properly enough, takes no share, and lays down no conditions; it is regarded as a purely medical question, which is left to the discretion of the Medical Officers. That being the case, it is obvious that the use of "medicinal restraint" should be a matter of deep concern to the medical authorities, and one in which the Medical Superintendent should personally and constantly interest himself. I have no hesitation in saying that this special care is not given in most English public asylums, and that in particular its supervision by the Medical Superintendent does not exist. This at least was my experience, and I have no doubt it would be generally corroborated. The most powerful drugs were habitually used in both the asylums in which I served, with very little regard to their possibly injurious effects. Especially was this the case with powerful hypnotics and sedatives and with croton-oil. It goes without question that drugs of this nature have to be constantly employed in asylums, but it should also go without question that their employment should be conducted with the greatest care. The indiscriminate and thoughtless use of powerful drugs is one of the greatest evils in modern asylum treatment in England, and in my opinion is productive in many cases of the greatest harm. It is so much easier, and saves so much time, to prescribe a strong sedative or hypnotic to a noisy and restless patient, than to try to find out, and if possible to remove, the cause of this restlessness and excitability. To give such a patient an injection of hyoscine, for instance, as is frequently done in violent and refractory cases, is, as Dr. Stoddart points out, "a refined substitute for hitting him on the head with a club." It is effectual, no doubt, just as the blow with a club would be, but it may do just as much harm, and may permanently injure the nervous system. But putting such a drug as hyoscine aside, as comparatively seldom used, the wholesale employment of bromide, chloral, sulphonal, paraldehyde, veronal, etc., for all and every

type of insane patient, irrespective of age, sex, mental state, or physical condition, seems to me hopelessly unscientific and irrational, as well as inhumane. As a matter of fact, these drugs are often used not only to keep the patients quiet, but, as I have said, to save the doctors the trouble of making a diagnosis, or finding out the cause of some intercurrent malady. But troublesome cases are not only kept quiet, they are kept *drugged*, a very different thing. Inconvenient but serious symptoms are thus often masked, instead of being detected and treated, and unpleasant and intrusive defects of administration are also masked, which might otherwise be noted. The Medical Officer's professional conscience, I fear, is too often drugged as well, with the result that he is disposed to take things as they are, and make no effort to amend them. His feelings are gradually blunted, as well as the patients' faculties.

I do not think this picture is overdrawn. Of course, there are numberless occasions in asylum practice on which strong sedatives and narcotics have to be employed, especially in acute and violent cases. Sleep for distraught minds and distempered nerves must be obtained by any means and at any cost, and is as important as rest for tired bodies, for sleep is pre-eminently the food of the nervous system. But for the hosts of noisy and disorderly "chronics" is there nothing to be done except to drug them with sulphonal or bromide? Might not the best treatment for such cases be in reality an improvement of asylum conditions, such as more fresh air, exercise, employment, amusement, and, above all, liberty, an improvement which continuous drugging tends even more to thrust into the background as not being demanded by drugged patients? These hundreds of routine sedative and hypnotic draughts, which are made up every day in most public asylums, and often given indiscriminately to patients on the mere word of a Head Attendant or Ward Charge, are they really necessary? I know how difficult

it is for a Medical Officer to avoid giving them, and must plead guilty to having given them many times myself without adequate thought, or possibly justification. But that was mostly in my early asylum days, before I had learnt from experience never to order a sedative draught without being personally aware of the patient's condition. The chief cause of the difficulty, of course, was the large number of patients for which each Medical Officer was responsible. I had three hundred and fifty, on an average, under my charge alone, and when my colleague was off duty this number was doubled, or even trebled. It was impossible to bear in mind the individual condition of all these patients. What usually happened was this. The long day's work was over, and one had settled down in one's room after dinner with a pipe and a book. Suddenly there was a knock at the door. One of the Head Attendants appeared. "George Brown, in Ward 8, is very restless and noisy to-night, and needs a draught." Most Medical Officers keep a few of such draughts in their rooms, to save themselves the trouble of going to the dispensary for them, and the temptation is almost irresistible to give the attendant the draught without further question. One is tired, and it is quite a long way to Ward 8. Irresistible or not, I know that in those days I seldom resisted it. The single draught was quite harmless, and more often than not was the proper medical treatment. But, perhaps on my rounds the next morning, when I interviewed George Brown, I would find him suffering from a furred tongue, foul breath, decayed teeth, and all the symptoms of chronic gastritis. Obviously, what he needed was not so much "chloral and bromide" as an aperient, followed by a digestive mixture, a special diet, and the extraction of the decayed teeth. After such treatment it is probable that his extra restlessness and bad temper, which may have been due to purely physical causes, would disappear. The sedative draught would, no doubt, quiet him for the time, but it would not cure his dyspepsia; on the contrary,

it would be likely to increase it. I have little doubt in my own mind that for the almost universal dyspepsia prevailing in asylums this continued drugging with sedative draughts is largely responsible, combined, of course, with the badly cooked food and the patients' defective teeth. The result of such indiscriminate drugging after a time is to make the patients dependent on narcotics, so that they can't sleep without them. Or, again, it may happen that the "restlessness" complained of is due, not to dyspepsia or constipation, but to the proximity of a noisy neighbour, to the patient's occupying a bed in an open ward instead of in a single room, to his being too thinly clad, or to half a dozen other causes, none of which are remedied by a sedative draught, or discoverable except by personal investigation by the Medical Officer. Yet in my experience few Medical Officers bother about such things, and fewer attendants. The fault, of course, lies with the former; but without an adequate Medical Staff such defects will never be remedied.

As important as the abuse of strong narcotics and sedatives is the abuse of powerful purgatives, such as croton-oil. Chloral, bromide, and croton-oil are the three sheet-anchors of all asylum medicinal treatment, and the worst in its effects of all three is possibly croton-oil. Again I need not repeat what I have already said, that for the vast majority of asylum patients aperients of some sort are at times absolutely necessary. Not only does their confinement render this necessary, but their mental condition. Nearly all insane persons, whether in asylums or not, are habitually constipated. And nothing tends more to clear their heads, improve their tempers, and abort or cut short a mental crisis, than the proper regulation of their bowels. This is a commonplace in the treatment of all mental patients. Nevertheless, the aperients employed should be properly chosen, medically supervised, and their effects carefully noted. They should never be given indiscriminately by the attendants, and the use of

"stock bottles" and routine treatment by the Ward Charges is to be deprecated. Thus employed, aperients are of the greatest service, and many an insane patient owes his recovery in large measure to their careful and conscientious use. But when I have said that I have said everything. In most public asylums aperients are never carefully prescribed or conscientiously employed. In nine cases out of ten they are never personally prescribed by the Medical Officers, but are given at the whim of attendants and as a matter of routine. Ordinary aperients thus given do not do much harm. But it is very different with a powerful drug like croton-oil, which can only be prescribed by medical order. And I have a very grave indictment to bring against the medical usage of most public asylums in this matter. When I first took office I found the use of croton-oil almost universal. This powerful purgative was only dispensed in two-minim capsules (a very strong dose), and not a day passed without the attendants specifying a certain number of cases in each ward that required "crotons." In some cases the patients were constipated and really needed an aperient, in most they were simply troublesome or refractory, and this was the recognized method of "taming" them or keeping them quiet. No doubt, in many cases, croton-oil is a valuable purgative, it acts quickly and thoroughly, and if the patient is young and strong does no harm when occasionally used. But the cases are not carefully selected, the drug is used much too frequently and indiscriminately, and, worse still, often as a "punishment." It is in the latter light that all patients regard it. All insane patients are at times exceedingly troublesome; attendants are often harried and at their wits' end to keep them in order; and to give them a "croton" is such an easy and effectual way of quieting them that it is no wonder that attendants advocate it. They are only human after all. None the less this routine employment of croton-oil as a means of maintaining order is sheer cruelty,

and to be sternly deprecated. It is probably responsible for more harm than all the other drugs used in asylums put together. I have little doubt in my own mind that it is the indirect cause of more cases of "colitis" or "asylum dysentery" than is ever suspected. The Board of Control are constantly referring in their Reports to the prevalence of "colitis" in public asylums. I have often wondered whether it has ever occurred to them that among the unsuspected causes of this very serious and infectious disease the abuse of croton-oil may be one. "Asylum dysentery," of course, is due to a specific organism, but it needs a favourable soil to thrive in, and what more favourable soil for its reception and transmission can be imagined than a bowel weakened and inflamed by constant and drastic purgation? The reader may be ignorant of the effects of croton-oil purgation, for the drug is seldom used in civil life. But I can speak from personal, as well as professional, experience. I once took a two-minim capsule myself, for I was anxious to judge of the effects of a drug in such constant use. The experience was extremely unpleasant, and confirmed me in my profound objection to the drug. The bowels, after a strong croton purge, may be opened ten or even twenty times. Often there is severe griping as well, and the patient may be violently sick. The pulse-rate is markedly lowered, feeble cases may become blue and cyanotic, and may even faint. I was told by one of the Head Attendants in this asylum of a patient being carried off one of the airing-courts into the hospital, vomiting and violently purged at the same time, and in a state of complete collapse. This is unusual, no doubt, but it shows the strength and dangerousness of the drug. The more usual result is for the patient to be violently purged a dozen times or more, and his vitality lowered for twenty-four hours, after which, if young and strong, he recovers and is apparently not much the worse. But the reader may imagine its effects upon weak and elderly patients,

and I have known attendants recommend such for this treatment, and callous and ignorant Medical Officers prescribe it. Even in young and vigorous patients its effects should be carefully watched, and it should never be repeated except at considerable intervals. For these effects are not simply those of purging, the bowels are not merely opened, they are scoured out, and, as the strips of mucous membrane found in the stools testify, they are not only scoured out but flayed. As I have stated, this is no guesswork on my part, but the result of personal experience. And I would suggest to all Medical Officers of asylums, who are in the habit of prescribing croton-oil for their patients, that they should repeat my experiment, and learn for themselves what its results are like. "A fellow feeling makes us wondrous kind," and probably, if they took my advice, they would think twice before prescribing this drug so indiscriminately. Acting upon this principle, I once told an ill-tempered attendant who was always getting into trouble with his refractory cases, and recommending them for "croton treatment," that if I ordered a croton for anybody it would be for him, as needing it more than the patients did. I shall never forget the man's face. But it had its effect, and for a long time afterwards I had no patients recommended for "crotons" from that ward.

I also gave my Ward Charges to understand that I would never prescribe "crotons" except for severe and intractable constipation in young and healthy subjects, or without personal investigation of each case, and that its use as a punishment in my wards would henceforth be prohibited. Not only was this use of it brutal and degrading, it was taking a mean advantage of a patient's defencelessness. For no patient *knows* he is taking croton-oil, otherwise he would, in ninety-nine cases out of a hundred, refuse it. The capsule is dissolved without his knowledge in his food, and this fact alone is enough to condemn it in most humane people's eyes, except in

unavoidable cases, which fortunately are rare. The older patients, when they suspect the existence of croton, will often refuse their food. They know and dread its effects too much. The younger and more unsuspecting fancy after taking it that they have had a bad attack of diarrhœa. I also reduced the dose from two minims to half a minim, and ordered a supply of this strength before I had been many months in office, and never employed anything stronger afterwards than half or one minim doses. At times, of course, it is absolutely necessary to give this drug, for asylum constipation is a very obstinate form of the complaint, and often only yields to heroic measures. But a patient should be kept indoors for the day after, especially in winter time, for he is very apt to take a chill when weakened by purging. How many patients, improperly clothed and with their constitutions lowered by long confinement and bad feeding, have had their health wrecked and their lives shortened by being sent out into the cold and wet airing-courts during "croton treatment" I should not like to say, but, if my experience is any test, they must be counted by hundreds in the course of a few years. I feel I must apologize to the reader for so long a digression upon so unsavoury a subject, but I trust I shall be forgiven when its great importance is realized.

CHAPTER V

WORKSHOPS AND LABOURERS

I WILL now take up the thread of my narrative where I left it at the end of Chapter II. The reader will recollect that I was on my morning round, and had got as far as the airing-courts. It is my day for visiting the workshops, laundry and farm, and I will ask the reader to accompany me. Leaving the airing-court, I turn down past the female ward blocks and the female hospital and enter the first workshop. There are four workshops in this block: the coir-picking shop, the tailor's shop, the bootmaker's shop, and the printer's shop, the last of which has been closed during the war. There are some dozen male patients working in the coir-picking shop, picking the coir, or cocoa-nut fibre, with which most of the mattresses used by the patients are stuffed. It is unpleasant, unhealthy work, reminiscent of oakum-picking to those who have been in jail or worked as "casuals" in workhouses, and patients with weak chests or a tendency to bronchitis should not be employed at it, as the dust given off causes considerable bronchial irritation. But it is a very useful work from the point of view of the asylum authorities, for it saves them much expense. In the tailor's shop some half a dozen patients are now employed under the superintendence of the asylum tailor, who is also a part-time attendant. In the bootmaker's shop only one patient is at present employed, for not many lunatics can be trusted with sharp tools. He is a mild inoffensive old man, who has the distinction of

never uttering a word. Here I may say that most of the asylum boots are made, and all of them are mended on the premises, and precious bad boots they are. Scores of cases of blistered heels and inflamed toes and festered corns are caused every year by the roughly made and badly fitting boots which the patients are compelled to wear. This is one of the minor evils of asylum life, and has been much aggravated by the war, owing to the dearness of leather and the difficulty of obtaining it. But minor though it is, it is not negligible, and could be mitigated by allowing the patients to wear their own boots as long as possible, and when they could no longer afford this, by taking more trouble to fit the boots to the wearer instead of the wearer to the boots. As it is, the boot trouble, like the teeth trouble and the spectacle trouble, which I shall refer to later, is a constant source of discomfort and minor misery.

From the workshops I cross over to the laundry, which provides one of the most important and useful employments to which patients are put, women equally with men. The laundry is the stepping-stone to liberty for more patients than any other workshop. For only the best and most trustworthy patients are employed there, and few decline to take the job, though it is not a particularly healthy one, because they know that in many cases it is the half-way house to freedom. There are a score or more employed there this morning under the charge of the laundryman attendant, and I stop to chat with three or four, whom I am sending up for discharge at the next meeting of the Board, to satisfy myself as to their mental progress. From the laundry I cross over to the boiler-house, and thence to the engineer's shops, where three or four of the more intelligent patients are working. Two of these are also on my list for the next discharge, one of whom, an old man of past sixty, has been in the asylum for twenty-three years, and from all accounts has been fit for discharge for many years past,

had anyone ever taken the trouble to interest himself sufficiently in his case.[1]

As I pass down the road on my way to the farm (for the asylum grounds are extensive, and occupy some three hundred and fifty acres, and the farm is a quarter of a mile away), I encounter a string of patients garbed in white overalls, who are wheeling boxes on barrows under the charge of an attendant. This is the "closet-barrow gang," and numbers twelve in all, and it has been at work, with an interval for breakfast, some four and a half hours. Theirs is the most unpleasant and unhealthy work of all. They are mostly a repulsive and degraded-looking crew, being as a rule the most demented and imbecile type of asylum inmate. In fact, it is only this type of dement who would consent to do the work. None of them, of course, are forced to take on the job; they are persuaded to volunteer for it by the inducement of a few extra "luxuries," such as an ounce or two more a week of asylum "shag," or a little snuff, if they prefer it, and a little additional food. But they are so mindless that their freedom of choice is mostly nominal. The work of emptying the asylum closets must, of course, be done by somebody, and it is much cheaper to employ asylum labour than to get it done outside. Emptying earth-closets is a class of labour which, though unpleasant, is common enough in various parts of the country, and the particular type of patient employed in this instance is certainly not likely to suffer from undue fastidiousness. Were there no alternative to the earth-closet system there would certainly be no harm in employing healthy lunatics to empty the closets, if they were not averse to the job, provided also they were well fed, well clothed, and properly compensated, and that every care was taken to make the work as little exhausting and unhealthy as

[1] This patient was discharged on my recommendation at the next meeting of the Committee. He might have been discharged years before.

possible. As a matter of fact, in the case in question, none of these conditions were complied with. There was no necessity for the existence of the earth-closet system at all. Main drainage was already in existence in the asylum grounds, it was easy of access, the Superintendent's house and the Medical Officers' quarters were already connected with it, and earth-pipes, I believe, had been laid to most of the main buildings. It was simply a question of expense. To save this expense an antiquated and obsolete system had been allowed to remain in use for many years, totally unsuited to the needs of an institution containing some three thousand patients. The matter of instituting water-drainage has, I am told, been up before the Visiting Committee on many occasions, and has always been turned down on the score of expense. Yet the county in which the asylum stands is one of the richest in England, and the few thousands needed to connect the asylum with the main-drainage system would probably not have meant more than an extra penny on the rates. That, to my mind, disposes of the financial aspect of the question.

The number of the closet-barrow gang was, as I have stated, about twelve, but often less, owing to the difficulty of recruiting patients for this type of work. They worked on an average for four or five hours a day, beginning at 6 a.m.,[1] summer and winter, with half an hour off for breakfast. In dry weather they were provided with overalls, in wet weather with macintosh capes. But the laborious and unhygienic nature of the work, the long hours, and the constant exposure to wet and cold, especially on the dark winter mornings, is a strain on the strongest constitutions.

In the winter of 1917, when I had only been three months in office in this asylum, my senior colleague on the male side was laid up with influenza and pneumonia,

[1] The hour was changed to 7 a.m. in 1918.

and for five weeks the whole work of the male side, which meant the care of nearly a thousand patients, devolved on my shoulders. Included in my extra duties was the charge of the hospital wards. It was not long before the usual winter crop of bronchitis and pneumonia began to make its appearance in the hospital. It happened that among the new arrivals, within a day or two of each other, were two of the "closet-barrow" gang, one of whom nearly died of pneumonia. I forget what the other case suffered from, but fancy it was acute inflammation of the kidneys. He, too, nearly died. I was very busy at the time, but the coincidence of two members of this gang falling sick at about the same time set me thinking, and I took pains to make myself more acquainted with the conditions under which these men worked. When I spoke to the Head Attendant on duty, he asked me if I had seen where the men had breakfast. I had not, but naturally supposed that the men had breakfast with the others in the dining-hall. On accompanying him to the place indicated, I found it was a stone-paved, bleak, miserable-looking outhouse, looking due north and completely exposed to the weather. I remarked to my companion on the absence of a door. It appeared that an attendant had once been found smoking in this shed when on duty, and to prevent such a thing happening again the Superintendent had ordered the door to be taken off! To the ordinary mind this seemed a singularly futile and peevish mode of disciplinary action. I pictured to myself these men on those bitter winter mornings (it was snowing hard as we talked), working in the rain and snow and fog, coming into this shed for their rest and breakfast of weak tea and bread and margarine, half-starved, miserable, friendless. To feed and shelter men of broken constitution, as most asylum patients are, in a place like this was little short of an outrage. And this had been going on, as I was informed, for two years, though I learnt from the same Head Attendant that the

Superintendent's attention had more than once been drawn to the matter without any result.

I said no more at the time, but I determined then and there to make further inquiries. The first thing, obviously, was to report the matter forthwith, and make sure that the shed was no longer used for this purpose. I at once interviewed my sick colleague, with the result that the Superintendent was approached the next day, and by his order the gang were for the future breakfasted under proper cover.

But the fact that this particular wrong had been in existence so long, and was only exposed by my chance discovery, set me thinking. It occurred to me that if members of the closet-gang were constantly getting ill in the present, and if this were due to the conditions under which they worked, the same result had probably occurred in the past. I determined to investigate the matter further. With this object I examined the Register of Deaths. A Register of Deaths is kept in all asylums, and the Commissioners are very particular that it is posted up to date and accurately filled in. I obtained from the senior Head Attendant the names of those who had been employed on the closet-barrows for the past year. Having obtained the names of the patients, many of whom were still working on the barrows, I looked up those missing in the Register of Deaths. Sure enough, among the deaths for 1917 were the names of three members of the closet-gang. L. H., aged fifty-six, had died on January 19, 1917. The cause of death was certified as *pneumonia*, and he had been ill only five days. T. S., aged forty-three, had died on March 16, 1917, also from *pneumonia*. He had been ill only two days. J. H. E., aged forty-one, had died on June 9, 1917, from what was certified as "colitis," or asylum dysentery. He had been ill seven days. I found out from inquiry of the Ward Charge of the ward to which these men had belonged, and whose cases he remembered well, that they

had all been working up to the time they had been taken ill. This fact, if true, is very important, for it meant that *they had all been taken ill at their work.* The first two cases were simple enough. These were both cases of pneumonia, and both had occurred in winter. The cause of death in the third case was not so clear. He was certified as having died of " colitis," but inquiry from the Ward Charge elicited the fact that the man had suffered from an ischiorectal abscess for some time previously. These abscesses are situated close to the rectum, and are very painful. Further, they are constantly associated with tubercular disease of the lungs. With such a history, it is only too probable that the man had been phthisical, and that the tubercular diarrhœa, which is often a feature of this disease, was mistaken for that resulting from colitis. If the man was consumptive, he ought never, of course, to have been employed on the closet-barrows; if he died of " colitis," the particular nature of his employment may well have been a predisposing cause of his illness, as the germ of this disease is very prevalent in asylums and the disease very infectious. In fact, the prevalence of this germ in the excreta of asylum patients is a very strong argument against the system of earth-closets, for the risks of infection are obviously very great. Be this as it may, the fact remains that all these three men had died in the first months of 1917, after a few days' illness in each case; that all had been employed on the closet-barrows; and that the first two, at any rate, had contracted their fatal illness under conditions expressly calculated to induce it.[1] I am not saying, of course, that pneumonia any more than consumption is caused by catching cold or sitting in wet clothes. We know that both these diseases are, like colitis, due to a specific germ, but we know also that susceptibility to them is produced by just such conditions as these patients were exposed to,

[1] As the usual number of patients employed on the closet-barrows is about twelve, this makes a mortality of 25 per cent. in six months!

and to which the insane are particularly prone to succumb. I make no further comment on these three cases. I was not in office at the time, and though the facts can be corroborated from the Case Books and the Register of Deaths, and it is open to anyone to draw inferences from them, this book is not a record of inferences, however legitimate, but of facts that have come within the personal cognizance of the writer. I may add, however, as included in this category, the very significant fact that, since the breakfast-shed was disused, no other deaths took place among the closet-gang during the remaining eighteen months of my term of office, and no illness necessitating the admission of any one of its members into hospital.

It is possible, of course, that after perusing the above account, the reader may be among those who are inclined to say, " After all, what does it matter if a few lunatics, more or less, do die. Surely it is the happiest fate that can happen to them. Who would wish to keep alive mindless human animals, whose restoration to sanity is practically hopeless ? " A sentiment so frankly cynical as this may be common enough, but a moment's thought will be enough to condemn it. It not only runs counter to every tenet of ordinary humanity, but to all those instincts of a progressive civilization which have embodied themselves in laws specially enacted to protect the weak and helpless, of which modern lunacy legislation is a conspicuous example. Death may be a merciful release in many cases of incurable mental, as of incurable physical, disease, but we are not therefore justified in hastening it by wilful neglect or official apathy. If we were, why is there so much official outcry in the case of the suicide of a lunatic ? No event meets with greater condemnation from asylum authorities when its cause is due to negligence or carelessness. None is so strictly investigated or more severely punished. Besides which, not all lunatics are anxious to die ; many are as tenacious of life as most sane people. The chronic dements, especially, from whom

the "closet-gang" was mostly recruited, would certainly not choose to get pneumonia and die if they could help it. Their lives, mindless and animal-like as they are, have certainly an attraction for them. It is usually the recent cases, the sufferers from acute mania and melancholia, that wish to die, and they as a rule are the most recoverable. But whether life is sweet to a lunatic or not, it is no business of ours to help him out of it. The chief reason for confining lunatics in asylums at all is to care for them and see that they come to no avoidable harm, even if we make no attempt to cure them. And here I must leave the matter. If it is one of the worst I met with, it is only one out of many cases of injustice and wrong from which the inmates of our pauper asylums under the present system are allowed to suffer.

I observed a little while back, when speaking of the expense which asylum labour saved the authorities, that such labour, especially such unpleasant and unhealthy labour as emptying the earth-closets, should at least be adequately remunerated, even though such remuneration were not in cash, but only in its equivalent. The subject is an important one, and needs further discussion. A great deal of work of one kind and another is done by asylum patients, and this in the aggregate must save the authorities some thousands of pounds a year. But no asylum worker in my experience was ever paid for his work. He was given, it is true, a few "extras," such as a little more tea, tobacco, or snuff, and sometimes a trifling addition to his diet, and he had besides a few privileges, such as sitting up later at night and smoking in hall, which the non-workers, or, rather, those who can work but will not, did not get. But this was all, and, to quote Dr. Mercier's words, "this is not enough, nor nearly enough, to reward those who spend a lifetime, it may be, of patient and unremunerative toil in the interior of a lunatic asylum." The injustice is obvious, and calls out for prompt remedy. If, as I have stated,

asylum workers save the authorities some thousands a year, to reward them at a cost of so many pence is to be a party to a flagrantly inequitable transaction. It is because they recognize this injustice (for lunatics are not all fools) that many patients, otherwise healthy and able, refuse to work, though employment of some kind or another would be their mental salvation, and for the curable cases their best chance of recovery. Yet so bitterly does the injustice of non-payment rankle in their minds, that many patients, most of whom come from the working classes themselves, refuse to do any work whatever. Not all, by any means ; sheer boredom, and the knowledge that the workshop and a good character for work is often the means of their recovering their liberty, induce the able-bodied and more energetic to work even for no payment. But the inducement would be far greater and more effective if adequate rewards were held out. There is no necessity that payment should be made in money ; there are obvious objections to such a mode. Nor, again, need payment be made in kind, as is usually done, for such payment does not satisfy. Dr. Mercier's suggestion of payment by means of counters, or a special asylum currency of " tallies," seems a very good one. If in every asylum grounds there was a grocery or general store, as might easily be managed, these counters (which might be made of some harmless material and have a certain fixed value) could be exchanged for anything the buyer fancied and which the asylum regulations permitted him to have, such as tobacco, light confectionery, fruit, playing-cards, stationery, etc. He would thus have the sense of possession and the pleasure of purchase, and, more important than either, he would have the feeling of the worth and recognition of his work and the satisfaction which this confers. Such a feeling would immensely increase his self-respect and sense of personal value, which the present soulless and machine-made system of asylum administration seems specially

designed to destroy. And it would stimulate by so much more his chances of recovery. For all these reasons, then, it is not only just but wise that asylum workers should be paid for their work, not in kind but in value. Another great advantage that would accrue from its practice would be, as Dr. Mercier observes, that patients could be punished for misconduct or wilful breaches of asylum discipline by means of fines, which would be quite as effective and far less harmful than the system of punishment now in use. How much more rational, and probably equally deterrent, it would be to mulct a wilful misdemeanant in work-coupons than to shut him up in a dark room! If such a patient were not a worker, it would still be possible to punish him, were that necessary, by depriving him of various "luxuries" and privileges. It is not, either, as if the coupon system had not already been tried and proved successful. It has long been in force in the Criminal Asylum at Broadmore. That institution, a quarter of a century ago, contained six hundred and thirty patients, and the sum annually credited to them in return for their labour came to more than £700, even at the absurdly low price at which the coupons were valued. This figure would represent, in a large asylum, a sum of over £3,000 a year, or a sum which, calculated on the present scale of wages, would mean, if outside workmen were employed, quite £15,000 a year, if not considerably more. Is it any wonder that the more intelligent patients should think that their work deserved better payment than doles of tobacco and snuff?

I will now return to my morning round, the account of which has been once more, but not undesignedly, interrupted by the above digressions. The farm is my next objective. This is situated in the asylum grounds, about a quarter of a mile away from the main buildings, and about half-way to the ánnexe. It is not of any great extent, and very little real farming is undertaken.

A certain number of cows are kept, sufficient to keep the patients and doctors supplied with milk, but the chief farming industry is the breeding of pigs. Most of the meat used in the asylum is contracted for outside. There are a few fowls kept, but no scientific poultry farming is carried on, greatly to the loss of the asylum. The farm gives employment to some thirty-five patients, under the control of the farmer and three or four attendants. The patients are more or less chronic dements, sufficiently harmless and trustworthy to be employed in farm labour and sufficiently intelligent to be of use. Most of them sleep in the farmhouse and in an adjoining villa, and they have their meals on the premises. The dinner is sent down from the main kitchens in covered tins, a bad arrangement, for the food is mostly cold on arrival. Farm work is healthy and not very arduous, and is popular in consequence with most able-bodied patients. It would be beyond the scope of my inquiry to describe the farming operations carried out in this asylum, but it was generally admitted that not half enough advantage was taken of the opportunities for making the asylum, with the exception of its meat supply, practically self-supporting. In particular, far too little attention was given to poultry farming and egg production, and a far greater variety of vegetables could have been grown than was the case. Only potatoes and the commoner kinds of vegetables were grown, and there was no fruit, except a few beds of strawberries and a few gooseberry bushes and raspberry canes, which, needless to say, were not intended for the patients. For the deficiency of fruit there was some excuse in the climate and soil, which was not suitable for most kinds of fruit, especially stone-fruit, owing to the poverty of the soil and the chemical impurities in the atmosphere. This did not apply to apples, and I am told that most kinds of apples would have done well, though I speak without any expert knowledge. But many more salad vegetables could have been grown, and when one remem-

bers how important an adjunct of diet for the insane are fresh salads and fruit on account of the vitamines they contain, it will be seen how little advantage was taken by the asylum authorities of their opportunities in this direction. A change from the eternal round of bread, bully beef, pork, bacon, potatoes, brussel sprouts and dried peas would have been greatly welcomed. The "intensive" system of French gardening was also quite feasible, and would have well repaid any extra expense, while conferring untold benefit on the health of the patients.

Especially would an extra supply of vegetables and garden produce have been welcomed in the war, when vegetables were so expensive and hard to obtain. But no steps were taken in this particular asylum to remedy this deficiency and to eke out the routine rations. There was plenty of land available and any amount of labour to be had for the asking, but no plots were given to the attendants to enable them to cultivate their own vegetables, though this was done in most of the neighbouring asylums, and was a greatly appreciated boon. Even when one of my colleagues on the Medical Staff, a locum tenens like myself, offered to cultivate a section of ground at his own expense, a very grudging consent was given. The sequel is still more instructive, for when the asylum potatoes ran short, his own were commandeered without payment, leaving him some £15 out of pocket on the venture—an instance of asylum "economy" for which he was doubtless unprepared, and which, as a foreigner, he probably still less appreciated. Not that he had any wish or intention to make money out of the transaction—his sole object was to add to the available stock of asylum food, and after repaying himself for his outlay, to give the patients in his wards a good Christmas dinner, by selling the extra produce to the asylum authorities. As it was, the patients were not benefited, but the asylum was in pocket to the extent of some £27, the market price of the potatoes commandeered.

NOTE.—As relevant to the subject of asylum administration, and thus falling within the scope of this inquiry, the two following incidents may fitly be appended to this chapter. Both are evidence not only of the lack of patriotism shown by the authorities of this asylum during the war, but throw an interesting sidelight upon their methods of government and their interpretation of their public duties.

When war was first declared, most of the members of the junior Medical Staff approached the Superintendent and asked permission to volunteer for military service. Though their application was very unfavourably received, and in one case at least was met at first with a point-blank refusal, nearly all the junior Medical Officers, like the patriotic Englishmen they were, within a short time joined up and were given commissions. Among those who did so was a Medical Officer who had already completed five years of asylum service. He had already twice applied to the Superintendent for permission to join the Army, and had been twice refused. On applying for the third time, he was given permission, but was told to "clear out" of the asylum in a fortnight. It happened that this officer decided to marry while on duty in France. Marriage being against the rules for junior Medical Officers in this asylum (a regulation upon which I shall have something to say later in this book), the officer in question, knowing he would jeopardize his future position and chances of reinstatement by marrying without permission of the asylum authorities, before taking the step made application to the Committee. His application was refused. For reasons intelligible to most people, especially to young officers at the Front, he decided to take the risk, and, having obtained permission from the military authorities, duly married. On the conclusion of the war this Medical Officer, who by this time would have completed ten years of asylum service, applied to the Committee for reinstatement. There was nothing against his personal character or medical efficiency: he had given valuable service both to the asylum and his country. But he had broken one of the asylum regulations, which had never been framed for the exigencies of war time, and had thus given the Committee a handle for dispensing with his services. But having regard for the fact that there was now accommodation in the asylum grounds for a married Medical Officer, and, in default of that, that he was prepared to take rooms for his wife and child outside, he had hopes that his application might be favourably entertained. At the next meeting of the Committee his case was again brought up, and his application once more refused. Against this decision there was no appeal, and so an asylum Medical Officer, who, one

would have thought, had deserved better of his country, and whose only disability was a technical offence committed under circumstances that should have appealed to any Englishman's generosity and sense of fair play, not only lost a post worth at present money-values at least £500 or £600 a year, but also the deductions that had been made from his salary under the Superannuation Act in respect of the pension which he is now never destined to enjoy. He has since taken up other medical work, and his asylum experience, which was valuable, has been lost to the community. This case seems to me an instructive one, but I leave the reader to supply his own comments upon it.

The second incident, though of a different nature, is equally instructive. It also has to do with the war and with the attitude of the asylum authorities to it, though in this instance the personal note is lacking. I need not say that the war was a subject of paramount interest to the more intelligent patients in the asylum, and that the war-news was eagerly read and discussed in the wards, as day by day the number of admissions of ex-soldiers, shell-shocked and mentally wrecked, was added to. The patients were to a man, and woman too, keen patriots and loyal in their sympathies; many of the male patients had themselves seen active service, and most had husbands and sons at the Front and had suffered personal losses. At last came the heart-stirring news of the Armistice and the victory of the Allied Forces, and we all, patients, nurses, attendants, and at least one of the Medical Staff,[1] were overwhelmed with joy and thankfulness. From every roof and window in England and the Allied countries fluttered flags of pride and exultation. But in the asylum of which I speak not a flag or symbol of victory was officially flown. The buildings stand high; a flag-staff on the clock-tower and a big Union Jack flying from it would have been visible for miles around. But not the faintest official recognition was taken of the event, not even the asylum syren was blown. From a ward on the female side came the sound of a cracked piano; one of the female lunatics had so far forgotten herself as to play the National Anthem. That was all. It almost seemed as if the authorities of this asylum, or at all events the Medical Superintendent, were unmoved by the fact that the greatest war in their national history had been won by Englishmen.

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[1] The main asylum Medical Staff at that time consisted of a Dutchman, of indefinitely "neutral" sympathies, an Australian conscientious objector and pronounced anti-Englander, an Irishman, whose views were not known, and the present writer.

CHAPTER VI

ASYLUM FOOD

Having visited the farm, my morning round is now over, and it is time for me to be back in the main dining-hall, where at noon some two or three hundred of the patients under my charge will be having their midday dinner. A Medical Officer is always expected to be in attendance or within call at meal times. For it sometimes happens that an epileptic patient may choke over his food, with possibly fatal consequences. And all insane patients are liable to bolt their meals and eat very much like animals.

Perhaps nothing in asylum life is so important from the patients' point of view as their daily meals, and one can understand and sympathize with their feelings. In the everlasting dreariness and monotony of their lives, meal times assume an exaggerated importance and become the main events of the day. Yet it is probably true that nowhere is this monotony more apparent and a greater source of dissatisfaction than in the meals served to the pauper insane in most of our large public asylums. As my own experience was confined to the conditions prevailing in war time, I cannot speak with any confidence of the pre-war dietary of asylum patients, which no doubt differs widely in different asylums. What I say, then, in this chapter regarding the dietary of the pauper insane must be regarded as confined to what I saw during the war. Even so, it reflects little credit upon the administration of the asylum in which my experience

was chiefly gained, and of which I give an account in this book.

During the war we were, of course, rationed like everyone else in these islands, but as the rationing was spread over an asylum population numbering considerably more than three thousand, it will be obvious that it was a comparatively simple matter to give everyone a fair share of nutritious food, and that any scarcity experienced should have been not of the prime necessaries of life, but only of such unessentials as would come under the head of luxuries. The matter resolved itself into one of fair and equal distribution, with special consideration for those who were most in need of it. For all that, it seemed obvious to me as time went on that there was anything but a fair and equal distribution of the available food, and that the patients were discreetly limited in what food was obtainable in order that the remaining members of the asylum population, i.e. the Medical Officers, attendants and nurses, and all those holding minor official posts, should not suffer. The evidence of this fact is, I think, brought out by the Reports of the Board of Control, which showed that during the whole period of the war there was a steadily increasing death-rate among the asylum inmates, which was attributable in the Reports to the prevalence of such diseases as tuberculosis, dysentery, pneumonia, and that new and somewhat mysterious "disease" euphemistically described as "senility," but which a leader-writer in *The Times*, to whom I shall subsequently refer, seems to have hinted at under the less pleasing but possibly more appropriate term of "starvation."

Perhaps the best way to illustrate the fact to which I am now referring will be to compare the dietary of the Resident Medical Officers during my term of office with that supplied to the patients, including the hospital patients, in the asylum, who were all supposed to share equally in the rationing system to which all were subject.

I will describe, then, how, in this period of national food-shortage, four asylum doctors, only one of whom was an Englishman, were fed. I only joined the asylum staff at the beginning of the fourth winter of the war, but as the food pinch was greatest from that time onwards, it follows that the food conditions of the Medical Staff were probably even more favourable before that date.

For breakfast there was porridge, bacon and eggs, marmalade and jam, unlimited bread and butter, a pint of cream, milk, tea and coffee. It is significant that the tea and oatmeal, which were the same as the patients were provided with, were of exceedingly poor quality, and the porridge was never properly cooked. On the sideboard there was an excellent cold ham, and sometimes potted meat or brawn as well. After the first six months the ham and cream disappeared, and we were rationed in butter, but everything else remained. During the whole war we always had bacon and eggs for breakfast, and though, as time went on, the bacon became rather coarser and the eggs less fresh, there never was a day on which we had not both, and plenty of marmalade as well. On Fridays we had fish *in addition to the above*, and on Sundays we had sausages as well as bacon and eggs. For lunch, except on Fridays, when we had fish, we always had a hot joint or ragout, varied with hash or shepherd's pie, and occasionally hot boiled ham, with bread and margarine and potatoes. There was besides a milk-pudding and any sweet that was left over from the previous night's dinner. Cheese, too, was generally provided, and we were allowed two pounds of treacle a week among the four of us. Dinner consisted of soup, a hot joint, either beef or mutton or pork, with two vegetables, and this was followed by two kinds of pudding, including milk-pudding, with coffee to finish up with. We were also allowed two bottles a week of dinner claret. None of us drank this, except on rare occasions, but it was always "on tap." For Sunday's midday dinner we had

soup, two roast fowls, two vegetables, and the usual two puddings. Sunday supper was mostly cold, consisting of chicken or meat, a milk-pudding and the remainder of the sweets left over from dinner. But there was always hot toast and buttered eggs, and sometimes soup and coffee as before. As the reader will have perceived, so varied and abundant was the food that it was often difficult for us to realize that there "was a war on," and I often felt that I was having more than my share. But with all this abundance there was a corresponding waste. Half-eaten puddings were left in the pantry cupboard until they went bad, and I have many a time seen large portions of quartern loaves, pieces of meat, bones, potatoes, etc., in the pig-bucket in the scullery. A competent housekeeper would have reported, even if she could not prevent, this waste, but I never saw any attempt to check it, though I many times expostulated with the perpetrators of it. Waste, I suppose, is inseparable from all forms of bureaucratic control, as was abundantly illustrated in the great Government departments during the war, but waste of good food, when many asylum patients were dying of "senility" for want of it, was little short of a crime. And all the time that the asylum death-rate was steadily mounting the Visiting Committee were coming to their monthly house-dinner, and were generously dined and wined at the asylum's expense, receiving, I was told, in addition from the grateful ratepayers an honorarium of a guinea a head for travelling expenses and as compensation for the time lost to their businesses. Oh, they manage these things very well in some of our County Asylums! And not a word appeared in any Report of the Commissioners during that time to show that they had the least suspicion of the possible cause of the advancing death-rate among the pauper lunatics about which they were so concerned. Might I suggest that, in some cases at any rate, it was not the war, nor the

difficulties of the food supply, nor yet the inexperience and incompetence of the temporary Medical Staff, that was the cause? It was the unjust and unequal distribution of the *sufficient and available food*, the combination of official lavishness and waste, the incompetent management, the inadequate heating arrangements,[1] the careless and unscientific cooking, the inefficient supervision, the neglect of opportunities for increasing the supply of asylum-grown vegetables—in a word, all the evils of the administrative system which I have pointed out in this book—that were the probable causes of the increased death-rate, not the war, though the war may have exaggerated and intensified them.

Let me now compare with this picture of the food supplied to the Medical Officers and resident asylum officials that of the food supplied during the war to the patients themselves, including those who were sick in hospital.

Breakfast consisted of lukewarm, tasteless tea, barely sweetened and of very poor quality, together with bread spread with a thin layer of margarine. For some time during my term of office porridge was given instead of bread and margarine, but it was always abominably cooked, and more like oatmeal soup than porridge. The patients much preferred the bread, which was fairly good and well baked, and of which they could have as much, in reason, as they wanted. Tea was the same as breakfast. The midday dinner varied within certain well-defined limits. On certain days of the week there was meat or tinned bully beef. This was served with potatoes or sprouts, or dried peas or beans. No bread was ever given with this meal while I was in the asylum,

[1] In one of the asylums in which I served the heating of the corridors and passages was suspended for weeks at a time in mid-winter, though the Superintendent, the Medical Officers, and the local executive staff revelled in an abundance of excellent coal.

a great deprivation, and one which the patients keenly resented. Sometimes pork, or chunks of fat bacon, took the place of mutton or beef. On one day of the week, usually Saturday, a thin and tasteless soup, coupled with boiled potatoes [1] was given instead of meat. A milk-pudding, usually of rice, completed the meal. The above three meals constituted the daily menu, and they were seldom varied, except within the limits mentioned, during the whole of my term of office. I never once saw any fresh salads or fruit upon the table, except what the patients' friends supplied them with. These, of course, were allowed to bring what food they could afford, such as fruit, jam, cakes, treacle, biscuits, etc., and in this way a much-needed variety was introduced into the asylum dietary. Had it not been for this extra food many more patients would undoubtedly have suffered gravely from malnutrition during the war, and the death-rate from "senility" would have been further increased. So that when we read, as we do read, of the recovery-rate being practically stationary, if not actually retrogressive, in our public asylums for the last fifty years, we are forced irresistibly to the conclusion that this lamentable result is probably due, among other things, to a lack of properly cooked and nutritious food, and is not, as the Commissioners would seem to suggest, a purely temporary and passing phenomenon due to the exigencies of the war. For though I had no experience of pre-war asylum dietaries, I made many inquiries during my term of office as to how they compared with the food provided in war time, and I gathered from what was told me by the Head Attendants of this asylum that, though more liberal and varied as regards meat and fish, the food was as ill-selected, as badly cooked, and as unappetizingly

[1] As the potatoes, after being peeled, were left standing in pails of water overnight, in preparation for the next day's meal, it is probable that much of their nutritive salts and vitamines were soaked out of them.

served as during the war. And it is difficult to imagine it being otherwise. Whatever the war did or left undone, it certainly had no effect upon the defects of English institutional cookery. Nor were the attendants drawn from a class that has any idea of what such defects consist in. It needed a war and foreign experience to teach that class how far behind that of all Continental nations in qualities of nutritiveness, variety, tastiness, and economy is the art of cooking in working-class and even middle-class English homes, to say nothing of English public institutions. English Tommies who have been billeted in France and Belgium will have learnt that if they have learnt nothing else, and such knowledge may in time filter through into the minds of their womenfolk, to the great gain of our national health and domestic economy.

Few things are so important in the treatment of insanity as good food, fresh air, exercise, recreation, suitable employment, and, needless to add, natural sleep ; and of these good food is quite one of the most important. The food should not only be good—that is, well selected, nutritious, and well cooked—but it should be frequently varied and appetizingly served. Dr. Mercier has some weighty words on this point, which, though written twenty-five years ago, are quite as applicable now as then. He says :—

The healthfulness of a variety of food is allowed by the best authorities ; but beyond its healthfulness, its desirability is beyond doubt. If the least crapulent of the managers of asylums will picture to themselves the monotony of a diet which admits of but seven changes—one for each day of the week—and the consequence to the appetite of knowing every day for a certainty exactly which of these varieties will be available, however little addicted he may be to the pleasures of the table, he can scarcely fail to see how disgusting this arrangement must become, and how desirable it must be for those who are subject to this régime, without the possibility of escape, to have some variety, or at least some uncertainty introduced. . . . With the resources at our disposal there

can be no real difficulty in affecting a greater variety of dinners, and its beneficial effect upon the comfort of the insane poor would be very great indeed. It is surprising that the managers in this country have not availed themselves more of the cheap and nutritious foods available in other countries, which are now so largely imported into England, and which, *properly cooked*, and served with the necessary additions which are required to make them tasty and to complete their nutritive value, would be highly relished, and would import into the monotonous dietaries of our asylums that variety which they so sorely need. (*Asylum Management*, pp. 63–64.)

Not only, however, should the diet for the insane be varied, but it should vary *in accordance with the form of insanity*. The same authority says again :—

The application of this doctrine to the dietary of the insane is manifest. The insane are conspicuous for their dynamical abnormity. They tend to exhibit mechanical energy in excess, as in acute mania, or in defect as in dementia. Epileptics, in particular, display most remarkable periodical explosions of nerve energy. Manifestly, then, the diet of the insane should be strictly regulated in accordance with the form and symptoms of their malady. Nitrogenous food should be given freely to the melancholic and demented, sparingly to the maniacal, and doled with parsimonious hand to those suffering from epilepsy. . . . Again, the ability to assimilate nitrogenous food diminishes as age advances, and persons over fifty need less, and should be allowed less, than younger people. (*Ibid.*, p. 62.)

So important is this question of food that too much attention cannot be given to the provisions made by the Lunacy Act dealing with this matter. It is provided by the Act of 1890 (Sect. 283) that :—

(1) Every Visiting Committee shall fix a weekly sum, not exceeding fourteen shillings, for the expenses of maintenance and other expenses of each pauper lunatic in the asylum, and of such amount that the total of such weekly sums shall be sufficient to defray such expenses *and also the salaries of the officers and attendants of the asylum*, and such weekly sum may from time to time be altered,

(2) If fourteen shillings a week is found insufficient for the purposes aforesaid, the local authority to whom the asylum belongs, may by order direct such addition to the weekly sum as to the local authority seems necessary, and every such order shall be signed by the clerk of the local authority, and forthwith published in a local newspaper.

(3) Any excess created by the payment of such greater weekly sum may, if the Visiting Committee think fit, be paid over to a building or repair fund, to be applied by the Committee to the altering, repairing, or improving the asylum, etc.

Now, it is my contention that these provisions are thoroughly unsound in their application, and to be condemned unsparingly. It will be observed that the sum to be spent on food is entirely undefined, and is included under the general head of "maintenance," out of which not only certain expenses of the asylum may be defrayed, but all the salaries of officials and attendants have to be paid. Also, that when any increase in the maintenance-rate of fourteen shillings a week is considered necessary by the Visiting Committee (as happened in the war), any excess over the ordinary rate may be devoted to the upkeep and repair of the institution, and not, unless the Committee so decide, to any improvement in the patients' food, which is considered apparently a negligible matter. The result is that while in normal times the Committee are not supposed to exceed the maintenance-rate of fourteen shillings a week, they may spend as little of this sum as they like upon food and upon the personal requirements of the patients, such as drugs, surgical dressings and the like. I maintain that this is a thoroughly bad principle, and in practice is productive of much hardship. A *minimum rate* should be fixed for food, which might vary with different counties, according as they were industrial, pastoral, or agricultural, but should be arranged by the Lunacy Commissioners after consultation with the local bodies, and *this minimum rate should never be decreased,* though it might, when necessary, be added to. No saving of the ratepayers'

pockets at the cost of the patients' food and drugs, no permission to apply any surplus over from the actual maintenance cost to any building or repairs fund, no obligation to pay salaries, wages and superannuation allowances out of a maximum maintenance-rate, as provided by the Act, should be tolerated. The permission, or obligation rather, to do these things tends in effect to encourage Visiting Committees to subordinate the sum spent on the patients' food and other necessaries to such maintenance expenses as above detailed, expenses which, however necessary, should fall upon the rate-payers or be a State charge, but should certainly not be defrayed at the patients' cost. Is the reader aware, for instance, that the cost of drugs per patient in our County and Borough Asylums came in 1918 to the ridiculous sum of six shillings per annum, and before the war was of course far less, while such a good authority as Dr. Weatherly estimates the *reasonable* cost of necessary drugs at about £3 17s. 9d. per head per annum? This was the cost per head in his private asylum containing only forty-four patients, but would of course be much less in an asylum containing some thousand of patients. And if this parsimony exists in the cases of drugs (and certain organic products, especially the glandular extracts, are destined in the near future to play an important part in the treatment of early insanity), we may be pretty sure of its existence in the case of food, and food is infinitely more important than drugs. In fact, as things are now, it is next to impossible to find out the approximate sum spent per head per annum on the patients' food, for the latter does not include what is supplied from the asylum garden and farm, which varies very much in different asylums. Thus, in those asylums where a comparatively large amount of food is supplied from inside sources it would probably be found that the actual expenditure on food represented only a small proportion of the maintenance-rate. According to the

Fifth Annual Report of the Board of Control, the weekly cost of food per head in the County Asylums for the year ending March 1918 did not come to more than five shillings and the fraction of a penny. And this represented no fixed minimum cost; there was nothing to prevent any individual Asylum Committee from reducing it to, say, four shillings per head, so long as the figure of the total maintenance cost fixed by Government, or the agreed increase to this for which they made themselves responsible to the ratepayers, was not exceeded, each Committee could do what it liked in the matter: the law was satisfied. It should be remembered, moreover, that in many cases the friends of even pauper lunatics contribute to the cost of their keep according to their means, and that this is a further reason for not allowing the cost to fall below a certain fixed minimum. It is highly unjust that any sums saved from the total dietary cost should be diverted to the general upkeep of the asylum. It remains only to add that, by whatever process arrived at, the expenditure on food is much too low in all our public asylums, and that, low as it is, there is no legal control over it. The matter is left entirely to the discretion of the Visiting Committee.

The Commissioners, in their Fifth Annual Report, are very concerned at the high and rapidly increasing death-rate among pauper lunatics, which had gone up from 12·1 per cent. in 1915 (a figure not reached since 1860) to 17·6 in 1917, and a still higher rate was foreshadowed for 1918. The incidence of this death-rate was, as we have seen, chiefly observable in the deaths ascribed to "senility," which had gone up from 14·3 per thousand in 1913 to 24·0 per thousand in 1917. As it does not appear that the actual number of senile dements in our public asylums showed any increase during this period, or that the average age of this class was any higher, it seems difficult to account for the increased number of deaths from "senility," unless, as seems likely, the word

was used as an euphemism for some other kind of "decay" not usually connoted by the term. No doubt lunatics tend to age much more rapidly than sane people, but when insane patients under fifty die in increasing numbers of senile decay, it is permissible to suspect the existence of some cause other than old age, some such cause, for instance, as may be seen at work to-day in the starving populations of Central Europe. Well might a leader-writer in *The Times* of September 7, 1919, sum up the situation in the following pregnant words: "We suspect there has been too great a worship of the calory, that modern idol of the laboratory"; and, referring to the number of mental defectives passed into the Army by the Recruiting Medical Boards, continued with the pertinent question: "Have we been sending some of our lunatics into the Army and starving the others?" Have we indeed? In my opinion the only possible answer to both questions must be in the affirmative. The Commissioners themselves seem to be of this opinion, at least as regards the first part of the question. Where they are wrong is, I believe, in attributing to the war the increasing mortality referred to in the second part. Properly selected, prepared and cooked, the food supplied, or that might have been supplied, to lunatics even in war time would have been sufficient to maintain them in fairly normal health.

Dr. Knowles Stansfield's letter to *The Times*, in answer to this leading article, takes for granted just those conditions which, in my experience at any rate, I have shown and shall show did *not* obtain. He says:—

With regard to the question of food, mental hospitals, like every other type of hospital, military or civilian, had to suffer privation, but not to the same extent as the ordinary public, seeing that every hospital has its own farm from which it obtains supplies of fresh milk, eggs, poultry, fruits, vegetables, and pork. . . . The method of estimating and regulating foodstuffs by their calorific content is the only correct and scientific way of dealing with the dietary, and particularly so in times of dearth such as the country

is passing through. If the food elements are properly selected and suitably blended (*a very large if* [1]), a dietary can be obtained which will supply the body with all its requirements, and will reduce to a minimum the wear and tear of the organs in eliminating waste.

To me this is an amazing statement. In the last asylum in which I worked, at any rate, very few eggs, no poultry and no fruit was forthcoming from inside sources, and I strongly suspect that this was true of many other County Asylums. It was with the greatest difficulty that we could get fresh eggs and cream even for the sick in hospital, while fish and poultry were practically unobtainable from the asylum authorities, and fruit was almost non-existent. My colleague on the male side constantly complained to me that in most cases when he ordered extra diet, such as milk-puddings, cream and eggs, for his sick patients, these were simply struck off the list by the Superintendent without his even troubling to ask for details. And the Senior Medical Officer on the female side told me much the same story. Yet all this time, as has been shown, the Medical Officers were being supplied for their private consumption with an abundance of excellent food as well as with a pint of cream a day, *and this cream was obtained by skimming the milk provided for the patients!* [2] This went on during the whole of the fourth winter of the war, and, I was told, during the three years previously, and was only discontinued in the summer of 1918.

It is facts like these, I repeat, and not the mere scarcity of food caused by the war, serious as this was, which,

[1] Words in italics mine.

[2] Presumably, though of this I am not sure, from that provided for our own use as well. As cream at this time could not be obtained from outside sources, except on a medical certificate, there was no other source from which it could have been supplied except the asylum milk. Whether the Superintendent's personal supply of cream was obtained in the same way I had no means of ascertaining.

in my opinion, account most readily for the general increase in our asylum death-rate during this period. But Dr. Knowles Stansfield will have none of it. In the same letter to *The Times* from which I have quoted Dr. Stansfield, with a dogmatic assurance which his knowledge can hardly warrant and with questionable taste, attributes the increased asylum mortality in war time to quite other causes. He writes :—

> The mental hospitals were depleted of a very large percentage of their male staff, Medical Officers, head male nurses, as well as juniors ; in some instances only a fifth of the original staff remained to carry on the work, supplemented by an inadequate number of inexperienced men advanced in years, commonly over sixty, and frequently over seventy years of age. It was impossible, therefore, for the patients to receive that standard of care and treatment to which mental hospitals had attained in peace time.

The reader is aware of my views of the general "standard" alluded to, but I know nothing of the mental hospital over which Dr. Knowles Stansfield presides, and which may have suffered from the inexperience of the medical substitutes to whom he refers. I only know that of the four medical locum tenentes who constituted the staff of the main asylum from which most of the facts of this book are taken, only one (myself) was over fifty, while of the three others, one was forty-eight and the other two were thirty-seven. No doubt we were all, especially at first, inexperienced in our duties, for we were all, with one exception, absolutely strange to the work of an ayslum, and nothing was done to help us. But the food shortage from which the patients suffered was certainly due to no action or inaction on our part, and it did not take long for all of us to become fairly competent in our work. What incompetence and inefficiency there was must, as I think I have proved in this book, be sought elsewhere.

There is still another statement in Dr. Stansfield's

letter to which I must allude, for it directly concerns the subject of this chapter, viz. Asylum Food. It is really an apology for the worship of that "idol of the laboratory," the calory, denounced by *The Times* leader-writer. Dr. Knowles Stansfield says, in his words just quoted, that "the only correct and scientific way of dealing with the dietary is by its calorific content." As the reader may possibly suspect, I totally disagree with that statement, and entirely uphold the views of the writer of *The Times* article. Nothing is more misleading, in my opinion, than to estimate the nutritive value of food in terms of "calories." If that were true, most dietetic problems would be easily solved, and we know that they are still far from solution. Even for ordinary sane and healthy men and women, living natural lives, the value of their food, i.e. its metabolic value, cannot be estimated in terms of chemical "calories." Much more is this true of insane patients who live artificial and unnatural lives, confined in asylums, deprived of their liberty, and exposed to mental and emotional stresses unknown to the outside world of the sane. A dozen causes may upset a lunatic's digestion and interfere with his metabolism, which for normal human beings are non-existent or rarely occur. The proverbs of all languages bear witness to the effect of the emotions upon the digestion and the assimilation of food. And in nearly every lunatic both the intellectual and the emotional faculties are abnormal. As a consequence, dyspepsia, in all its forms and with all its disabling effects, is rife in all asylums. It is not only the "chemical elements" of the food which require to be "properly selected and suitably blended," it is the foods themselves. I do not mean to say, of course, that "calory" values are unimportant, and that foods deficient in the proper proportions of these are as nutritious as foods containing them. All I mean is that the nutritive value of the food, leaving the personal factor for the moment out of the question, depends more

upon its palatability and digestibility than upon the number of "calories" it contains. It is not what we eat, but what we assimilate, i.e. in nine cases out of ten, what *we enjoy eating*, that nourishes us. Digestion, we know, "waits upon appetite," and appetite is largely an emotional affair. It is in the proper selection, preparation, cooking, and serving of the foods themselves that their nutritive value consists. All the necessary "elements" may be there, all the required number of food "calories," but if the food itself is wrongly selected, badly prepared, imperfectly cooked and unappetizingly served, its actual nutritive value will be correspondingly lowered, though its chemical value may be unimpaired. For our digestive organs are not like chemical test-tubes and retorts, lifeless and mechanical things, they are living organs responsive to mental and emotional impulses. Let Dr. Stansfield eat one of his own asylum meals, of which he speaks so highly, under the constant stress of a strong emotion, such as anger, fear, depression, disgust, anxiety or what not, from all of which lunatics frequently suffer, and he will not be disposed to estimate its value entirely in the terms of "food-calories." Let him repeat the process day in and day out for months and years together, and he will then perhaps begin to understand how important are the subjective and emotional accessories of digestion, and no longer speak of it in language befitting a chemical process carried on in a laboratory.

Before leaving the question of asylum food—and it is one of the most important questions concerned with asylum administration—I should like to repeat once more my conviction of the value to be obtained from a more liberal addition to the dietary of the insane of fresh salads and fruits, owing to the presence of what are called the "vitamines" contained in the latter. This question of "vitamines," or "accessory food products," has only lately come into prominence, and deserves the closest consideration from those responsible for asylum dietaries.

The method of its discovery was interesting. It was found that birds fed for any length of time on polished rice pined and died, whereas if fed upon the unpolished grains they thrived. Obviously there was some indispensable element of food contained in the husk of the unpolished grain. Further investigation proved that this element in the food, whatever its nature—and chemists are not yet agreed upon this point—existed in most vegetable and even animal foods, so long as these foods were alive, or had not been subjected to too great or prolonged heat, as in cooking or boiling. Hence the name of "vitamines." It has been suggested that much of the nutrition-value of the proteids and carbo-hydrates themselves may depend upon the presence and activity of this vital element. If the truth of this fact is borne out by subsequent experiments, it will be seen at once how important is its bearing on dietetics, and that it may render obsolete and even absurd the thoughtless worship of that "idol of the laboratory, the calory." It will at any rate emphasize the importance of uncooked fruit and vegetables in our dietaries, and will show in what the main defect of this "calory worship" really lies, or rather in what the true nature of the "calory," as an index of the "work-value" of foods, really consists. Incidentally, too, the vegetarians will score rather heavily over the meat-eaters. Without going so far as to say that the insane are more likely to be restored to mental health on a vegetarian than a meat diet, there seems little question that they might be largely benefited by the inclusion of more fresh fruit and salads in their diet. What fresh fruit the patients got was usually supplied by their friends, and their eagerness to get it was attested by their frequent demands for it in their letters home. Without this added fruit ration, which, according to Dr. Knowles Stansfield (and I entirely agree with him), ought to be obtainable from every asylum garden, there is no doubt that the patients' health would still further

deteriorate. But whether obtainable from the asylum garden or not, its adequate provision should be obligatory on all Visiting Committees. It is just as important, and in some types of insanity far more important, than butcher's meat. In fact, the vegetarian treatment of epilepsy, of which the late Dr. Charles Mercier was a strong advocate, already promises results of great importance. So far as I know it is almost wholly ignored in this country.

It may be thought that the contention urged in this chapter that asylum patients were in many cases stinted in available food during the war may be merely a personal impression, and in any case is insusceptible of proof. That direct proof of the statement would be difficult to obtain is no doubt true. It may be objected, besides, that as most necessaries were strictly rationed, the quantities per head of these could not be increased. But many foods were not rationed at all, such as milk, eggs, fish, vegetables etc., and the quality of such as were could have been raised by raising the maintenance-rate. As a matter of fact the maintenance-rate was raised by several shillings a week in most public asylums in the course of the war, but this increase did not in my experience make any difference to the patients' food, which grew steadily worse. The extra rate seemed all to go in increased official salaries and wages. But my argument is that not only could the *quality* of the available food have been greatly improved, but also its variety, and chief perhaps of all, its distribution.

CHAPTER VII

THE SUPERINTENDENT'S OFFICE

I HAVE now given the reader a brief insight into the daily life and experiences of an inmate of a pauper asylum, but before going on to a discussion of those features in which, as I hope to show, radical alterations are imperative, and are in fact long overdue, it is necessary to study in some detail the governing bodies and officials who are responsible for the administration of all lunatic asylums, and for the care and comfort of the patients contained in them. These are the Visiting Committee, the Medical Superintendent, the Assistant Medical Officers, and the attendants, male and female. Under the present system the Medical Superintendent is the head not only of the medical, but also of the executive, department. Under him are numerous other officials, such as the Secretary and Treasurer, the Chief Clerk, the Chief Engineer, the Matron and Housekeeper, etc. All these, though legally under the authority of the Visiting Committee, are practically subordinate to the Medical Superintendent, and take their orders from him. The Visiting Committee themselves are responsible to the Commissioners in Lunacy, or as they are now called, the Board of Control, which again is responsible to the Lord Chancellor and the Home Secretary, and thus to Parliament. Leaving the discussion of the Visiting Committee and Board of Control to a later chapter, I will in the first place consider the subject of those officials more intimately concerned with the medical administration of the

asylum, viz. the Medical Superintendent, the Assistant Medical Staff, and the attendants.

One of the most important aspects of asylum administration, and one upon which varying opinions have long been held, is the position and duties of the Medical Superintendent. My views will probably be violently opposed and hotly criticized by those who hold this office, but they have been formed as the result of personal experience and prolonged thought, and as such I shall not hesitate to express them. For this question is, in my opinion, the key to most of the evils which inhere in our present system of asylum management, a contention for which I have already produced evidence, and for which it remains now to explain the reasons. In my opinion these evils are attributable almost entirely to the dual character of the Medical Superintendent's office, viz. as Chief Medical Officer and Executive Head of the Institution. This combination of official duties inevitably results, in my experience and that of most other writers upon this subject, in the practical subordination of the Superintendent's medical to his executive duties. In most of our public asylums the Medical Superintendent takes far too little part in the strictly medical side of the administration, which he leaves almost entirely to his Assistant Medical Staff. For this, of course, there are obvious reasons. In large asylums not only is the executive work very onerous and varied, but it is work that gives a Superintendent a much greater sense of personal power and authority, and a much greater opportunity of ingratiating himself with and acquiring influence over his Visiting Committee, than the more humdrum and less interesting rôle of Chief Medical Officer. As Dr. Mercier remarks, "It is much easier to bring before the notice of the Committee, and gain credit for, good administrative work than good medical work." Of the latter the Committee knows little, and as a rule cares less. Their test of efficiency in a Superintendent is not

"Does he devote himself to his patients?" but "Does he bring down the bills?" This division of duty and preoccupation with executive work would not have the bad effects undoubtedly attributable to it if the Superintendent did not at the same time in virtue of his office exercise supreme medical authority. In the matter of the discharges of patients, for instance, one of the most responsible and important duties of the Medical Superintendent, with which I shall deal later on, the task of adjudicating in this most delicate and difficult question is entirely in his hands, and he need not, and as a rule does not, consult any of his colleagues. The result is that a man who may know less about the patients under his charge than anyone in the asylum, and whose knowledge of psychological medicine may have grown stale and out of date, is the supreme arbiter of their destinies, as he is the unchallenged guardian of their liberty. And most Superintendents are very jealous of their authority in this matter, and are little inclined to delegate it to or share it with their subordinates. Legally, of course, they are unable to delegate it; the Medical Superintendent is, under the Visiting Committee, responsible for the medical conduct of the whole asylum, and if anything goes wrong here it is he that is blamed. And in a properly managed and organized asylum it is perfectly right and just that it should be so. All the more reason, then, that this legal responsibility should involve and go hand-in-hand with an actual and not a merely formal medical responsibility. That a Medical Superintendent should be able to neglect his medical work and yet retain supreme medical authority over his asylum is not only unjust, it is an administrative absurdity. As a matter of fact, a Medical Superintendent is not officially or legally responsible for the upkeep of an asylum; that is the business of the Visiting Committee. But he *is* responsible for its medical conduct, and that being so, it is clear that his medical duties should take first place. And to properly

conduct these medical duties a Superintendent must not only have adequate knowledge of his profession, but he must also be personally acquainted with his patients. As things are now, this latter desideratum, in large asylums at any rate, is seldom fulfilled. It is impossible for a Superintendent who undertakes the entire executive responsibility of a large asylum to have sufficient time for the proper discharge of his medical duties as well As a consequence, these duties tend too frequently to be neglected by him, though he still exercises, as is his legal right, supreme medical authority over his assistant officers, attendants and patients.

The only possible remedy in my opinion for this state of affairs, at least in all asylums containing more than one thousand patients, is to separate entirely the offices of Medical Superintendent and Executive Chief. Upon this subject the opinion of the late Dr. Charles Mercier, who had been himself an Asylum Superintendent, and who, as an advocate of the existing single system of control in small and manageable asylums cannot be considered a biassed witness, has some very just and pertinent observations, which, for the reader's information, I will quote at length, as the matter is so important that it demands the closest investigation. In his work on *Asylum Management* Dr. Mercier writes :—

It is a vexed question, and a question of great complexity and difficulty, whether the Superintendent of an asylum should be, as the Act of Parliament provides and as the general custom allows, the Chief Medical Officer of the asylum, or whether, as is the case in certain asylums, the Chief Medical Officer should be restricted to purely medical duties, and the administration of the asylum in all matters not strictly medical should be placed in the hands of other officials, responsible not to him, but directly to the Committee.

On the one hand, it is alleged that when the lay administration is in the hands of the Chief Medical Officer, and he is Superintendent in fact as well as in name, his medical duties soon become swamped by his superintending duties ; that he ceases to take any share,

save of the merest routine character, in the treatment of the patients; that he neglects altogether the scientific investigation of insanity; that his time is entirely occupied in duties for which his previous professional training has not prepared him, and as to which he cannot, without years of practice, be anything but an amateur; that, in short, the duties for which he is fitted by education and training are neglected for duties for which he is unfit, and that, therefore, both sets of duties are inefficiently performed. Granted, say the advocates of this view, that a medical man, and especially Medical Superintendent of a large institution, should be an accomplished sanitarian, and should be able to prescribe the remedies for defective drainage or ventilation; yet what can a man, whose education has been that of a physician, possibly know of the duties of various artisans or of the nature of the materials with which workmen have to deal? What does he know of the comparative merits of a stockbrick, a malm, and a grizzle? Of the advantages of wrought iron, or cast iron, or steel in this position or in that? Of the difference between fir, pine, and spruce? Of the size and make of boiler requisite for the heating of such a cubic space of wards and so many baths? Of the number of pairs of boots that a competent workman should turn out in a week, and of the thousand and one points necessary for the effectual supervision of a staff of artisans and the correct estimation of the quality and quantity of their work? Is it not manifestly better, they say, that all technical matters outside his own immediate business should be removed from the superintendence of the Medical Officer, and that he should be freed from the burden of work of inferior character, and enabled to devote his whole time and attention to his proper duties—the care and treatment of the patients placed under his control?

On the other hand, it is said by the advocates of the system most prevalent that there can be but one captain of a ship, and one person in supreme control of a large institution; that it is manifestly out of the question to expect a gentleman with the education, training, and qualifications of a physician to act in subordination to a house steward, and that therefore the only alternative is to make the Chief Medical Officer the Superintendent; that the existence of several heads of departments, independent of each other, each responsible to the Committee alone, leads to division and uncertainty of responsibility, to struggles for precedence and preponderance among them, to strife and ill-feeling, which spreads to their subordinates and causes want of harmony, and therefore a deterioration of efficiency throughout the institution. They say, moreover, that with respect to the stores, it is wrong

in principle and disastrous in practice to withdraw from the Medical Officer the complete control of the food and clothing fo the patients; that these matters constitute a part of the medical treatment, as to which he must be allowed perfect freedom to judge and provide what is best, and as to which he must be trusted with full responsibility; that the employment of the patients under the supervision and instruction of the artisans is one of the most important means of treatment of insanity, and that if the Medical Officer is deprived of authority over the artisans, it become useless as well as dangerous to entrust the patients to their care, as has been found by experience in those very asylums to which the advocates of lay or non-medical Superintendents point as examples of their system; that unless the Medical Officer has complete control over the staff, alterations in the construction or in the fittings of the asylum may be made which give facilities for suicide or homicide to the patients, or render their treatment necessarily difficult or hazardous; that if the attendants be responsible to one officer for the condition of their patients, and to another for the condition of their wards and ward furniture, there are certain to be conflicts of authority which will be disastrous to discipline; that artisans never render to a steward the same respect nor the same zealous service as to a Medical Superintendent, nor are they ever as well in hand when subject to a steward alone as when they are controlled by a Medical Superintendent, who is presumably of higher social and professional status. Finally, that the safety and treatment of the patients, for which the Medical Officer must always be primarily responsible, are bound up so intimately and in so many ways with every portion of the asylum and everything that is transacted within it, that it is impossible to deprive him of any authority within its precincts, without at the same time restricting his opportunities of doing them good and preserving them from harm.

To these arguments the advocates of lay superintendence reply, that there is no reason why there should be any more friction between several heads of departments, all responsible to the Committee, than between the same heads, minus one, all responsible to the Medical Superintendent; that the nature of the food and clothing of the patients is determined by the Committee on the advice of the Medical Officer, and that the whole function of the lay authority consists in supplying the materials thus determined on and ordered, and that if there is any failure in this respect it can be rectified by appeal to the Committee; that the alteration to the structure and fittings of the buildings can be made with the advice or on the approval of the Medical Superintendent, without making him responsible for their execution.

The advocates of this view do not, however, give full weight to the advantage of the immediate rectification of such a defect, for instance, as badly cooked food or rancid butter; nor have they any answer to the reasons, which are certainly important, for investing the Medical Officer with the control of the artisans.

There are, it is obvious, great objections to both plans of management; the question, which is the best? does not admit of an immediate and decided answer, and the answer would probably not be the same in every case. In both plans the objections may be minimized, but cannot be wholly overcome. The objections to the Medical Officer being entrusted also with the superintendence would really not avail much, provided that the asylums were, in the first place, of moderate size, thoroughly well built, well fitted and equipped, and were not allowed to be extended. It is the constant extensions and alterations that every asylum undergoes which furnish the great objections to the function of Medical Officer being combined with that of Superintendent. The mere maintenance without deterioration of the *status quo* of an efficiently systemized administration is not a matter to tax severely the time or energies of a Superintendent. It is the continually recurring alterations and the constant need of extensions, with the consequent dislocation of the ordinary working processes, the extra strain on the staff, the reorganization of the service, which occupy his time and attention and keep him from his medical duties. It is, therefore, much to be desired that every asylum should be designed and fitted for the full number of patients that it is to contain, and that enlargements of an existing asylum should not be permitted. (N.B.—*In a concluding chapter, which deals with " The Ideal Asylum," it will be seen that the enlargement and alteration of such an asylum could be perfectly well carried out without seriously interfering with the comfort of the patients or adding to the duties of the Medical Superintendent. It is the existence of huge and unmanageable barrack-asylums that is the cause of all the difficulty in these cases.* M. L.)

There is another disadvantage attending the extension of the size of an asylum. It is unquestionable that the study of insanity is one of the most abstruse and difficult—perhaps the most abstruse and difficult—subjects that can occupy the mind of man. In consequence of this difficulty of the subject and its unattractiveness to most practical minds, and in consequence of the want of stimulus that attends the isolation from fellow workers in which most Superintendents live, the tendency of the Superintendent becomes year by year stronger, unless he has a special bent and taste for psychological studies, to neglect this portion of his duties,

and to devote himself more and more entirely to lay administration When his time and energies are absorbed in the erection of some new annexe or department to the asylum, he has every excuse and great justification for allowing his medical duties to lapse; and when once they have been abandoned for any length of time, the chance of their being resumed *con amore* and with the enthusiasm which is necessary for success is very small.

But if it be granted that an asylum is efficiently built and equipped in the first place, that the management is thoroughly well organized, and that extensions are forbidden, then, I think, that certainly in asylums of one thousand patients and under, and possibly in large institutions, the best method of management will be to make the Chief Medical Officer the supreme authority. . . . When asylums attain enormous dimensions and contain two thousand patients and upwards, it is doubtful whether this reasoning any longer applies. In this case the duties inseparably attached to the care of the patients individually—the statutory duties alone and the duties arising out of them—must absorb so much of the time of the Superintendent, that it is scarcely possible that he will be able to perform them efficiently and yet have time to carry out with even approximate success the administrative duties, which are correspondingly increased in volume. In these cases, therefore, the separation of the duties becomes almost a matter of necessity, and the fact that it is so seems to be an additional argument against the construction of very large asylums (pp. 192–196).

The reader will now have before him the considered opinion of one of the wisest and clearest-minded alienists in this country, and will be in a better position to judge for himself the pros and cons of the question. Speaking for myself, I have long ago made up my mind on the matter, and have no doubt at all that the two offices of Medical Superintendent and Executive Chief should be separated, if the medical welfare of the patients, which seems to me the chief object for which lunatic asylums were instituted, is not to suffer. After all, the Superintendent is a *Medical* Officer, and, to quote Dr. Mercier once more, "he is appointed primarily to care for and to treat the patients, and whatever other duties may be imposed on him, are intended to be, and ought to be,

subsidiary to this his first and greatest duty." His education and medical knowledge are adapted to this work, but he is *not* a professional engineer, architect, farmer, electrician, carpenter, gardener, and what not, although he may fancy himself a born expert in all these departments, and it seems absurd and unreasonable to give him executive authority over them. The law holds him, and justly holds him, to be responsible for the medical conduct of the asylum and the medical treatment of the patients; it does *not* hold him responsible for defects in construction or for the institution of alterations and repairs. That he must have, as I have already stated, supreme disciplinary authority over the whole asylum goes without saying. The possession of this authority would at once dispose of one of Dr. Mercier's objections to the divided control, viz. that under it the Superintendent would not have jurisdiction over the artisans who employed patients in the workshops, or be able at once to intervene in such matters as rancid butter or badly cooked food. Both these matters, as intimately affecting the medical care and comfort of the patients, would naturally fall under the Medical Superintendent's jurisdiction, as would the appointment and dismissal of all attendants and servants connected with the medical work of the asylum. It is only the House Steward's business that would pass directly out of his hands, and thus he would be left more free to concentrate his attention on his medical duties.[1]

[1] It may seem to many of my readers that the retention of supreme disciplinary authority in the Superintendent's hands is incompatible with the delegation of all executive responsibility to an independent official, and as this is a very important matter and the keystone of the reforms suggested in this book, a further consideration of it is necessary. Discipline, I take it, refers to matters of conduct, and in these matters there can only be one authority, and that authority must be supreme. Wherever conduct is concerned, the Superintendent of an asylum must be able to give orders, and such orders must be obeyed. That is not to say that

It is his neglect of these duties which, in my opinion, is responsible for most of the evils under which English asylum administration suffers at the present time. Bureaucratic methods of government and the worship of red-tape are, no doubt, responsible for many evils in addition, but a conscientious and hard-working Superintendent, devoted to his medical duties and to the patients under his charge, could counteract these to a large extent. But nothing can counteract or compensate for his neglect of medical duty, especially when accompanied with what is practically autocratic authority. Where such neglect exists, its effects penetrate downwards through the whole medical administration of the asylum, and affect all those with whom it comes in contact. Assistant Medical Officers, attendants, nurses, chaplain, matron, housekeeper, etc., all take their cue from the Medical Superintendent, with the result in such cases that the work is scamped or perfunctorily performed, petty injustice and tyranny are rife, the unhappy lunatics are regarded as so many cattle, even where they are not actually maltreated, and the system of taking as much and giving as little as possible is everywhere in evidence. The

he should interfere with the work of departments not under his authority, that he should give orders to engineers and electricians, and arrange the duties and hours of attendance of the workmen employed by the Chief Steward. In a word, everything that comes within the *medical* conduct of the asylum would be controlled by the Medical Superintendent, everything that fell outside this sphere would be under the authority of the Chief Steward. And where these two spheres overlap, a little goodwill on either side should be able to obviate all unnecessary friction. That they are not necessarily incompatible may be seen from the co-existence without friction of two spheres of duty closely similar to the above, viz. those of the captain and purser of an ocean liner. There can be only one captain of a ship, and in all matters of discipline an asylum should resemble a ship, and all breaches of discipline should be reported to the Medical Superintendent for him to adjudicate upon, or, if necessary, refer to the Visiting Committee.

belief that the asylum primarily exists for the sake of the welfare and comfort of the patients, and not for the benefit and aggrandizement of the officials concerned, is in such cases entirely lacking.

What, then, are a Superintendent's chief duties, and why does his neglect of them militate so greatly against the efficiency of the asylum? Without going into any detail, they are as follows: It should be the duty of every Medical Superintendent to make a daily round of the wards *in company with* all the Medical Officers in rotation. He would then get to know the patients himself and could be consulted as to their treatment. These consultations would be of the greatest service both to the patients and Medical Officers, and would reassure the former that everything was being done to help them. And to the Medical Officers they would give the benefit of what should be, but under the present system too often is not, the Superintendent's greater experience and knowledge. It is not necessary or desirable that a Superintendent should frequent the wards too much, or interfere with his subordinate officers' duties, but the morning rounds should be *de rigueur*. Yet this medical collaboration of Superintendent and Assistant Medical Officers is rarely seen in asylum practice.

This statement (to quote Dr. Mercier again) will seem incredible to a hospital physician, but it is in asylums the almost universal rule. In his medical capacity the Assistant Medical Officer stands to the Medical Superintendent in somewhat the same relation that in hospitals the house physician stands to the visiting physician. The subordinate in each case visits the wards twice daily and makes his reports to his superior, who visits at longer intervals. In a hospital the two invariably visit the patients together. In an asylum they never do so.

If we ask why, there seems only one answer: Either the Superintendent thinks too highly of his official status, or he regards his other duties as of more importance,

This absence of collaboration and consultation between the Superintendent and his junior officers shows its worst effects in the case of hospital patients. The hospital treatment of the insane in asylums leaves very much to be desired, and I shall deal with it later at more length. Not only are hospital patients left far too much to the care of attendants who have seldom had any training in nursing, but the question as to the advisability of performing an operation constantly turns up, and should be decided then and there by the Superintendent. Operations of any sort upon insane patients are deprecated by many Superintendents, and except in urgent cases, no doubt, are often inadvisable; but one cannot but suspect that a more usual reason for this reluctance may be a consciousness of their own lack of surgical skill and the suggestion of inferiority which is implied in leaving such operations to a subordinate. But there is no real necessity for the latter course. Were a visiting surgeon appointed to all public asylums over a certain size, this difficulty need not arise. As a result of this neglect or disinclination it is unquestionable that many patients in our public asylums suffer from affections that might be cured or relieved by surgical operation, while not a few of them die for the same reason.

Another of the Superintendent's medical duties should unquestionably be the classification of newly admitted patients, and the distribution of these to the wards in which they are to live. Dr. Mercier rightly lays great stress on this point, and observes that "it is of the greatest importance, for on it depends not only the comfort of the patient, but also his chances of recovery or improvement" (*ibid.*). Yet in how many of our asylums is this duty undertaken by the Medical Superintendent? I do not know, but I suspect in very few. In my experience, at any rate, it was left entirely to the Medical Officers, and in many cases often delegated by them to the Head Attendants, who were thus once more given

authority which did not properly belong to them and for which they were entirely unfitted. The Medical Staff would be responsible, of course, for the result, and their decision accepted as final, but in practice, and owing to the overcrowding of many of the wards, there was often no choice. Patients had to be placed where there was most room for them, regardless of the particular type of their malady. Were this occurrence only due to the exigencies of war time, it would be unfair to lay too much stress upon it ; but it was far otherwise. It is, indeed, a commonplace of all expert criticism of our system of asylum administration, and has been adversely commented upon by most Commissions of Inquiry set up to report upon it. How hardly it presses upon the happiness and comfort, as well as upon the chances of recovery, of individual patients will have become obvious to the reader of the preceding chapters. Its effect upon the scientific study of psychological and psychiatric problems by the Medical Staff is almost equally disastrous, and goes far to explain the backwardness of psychological medicine in this country. It is difficult to say which result is most disheartening. In any case, this lack of the proper discrimination and distribution of insane types strikes at the root of all efficiency in asylum administration and of all scientific and remedial treatment of insane states.

Still another of the purely medical duties which should devolve upon the Medical Superintendent is his attendance at, if not his actual performance of, post-mortem examinations. It is not too much to say that a great part, though by no means all, of our knowledge of what constitutes insanity depends upon the results of pathological research. Far as I am from believing that the chief cause of insanity must be sought in morbid changes in the material tissues of the brain, there is no doubt that these changes shed great light upon its symptoms and progress if not upon its origin, and help us to see how

closely the agencies of mind and matter are here intertwined, and how much the one depends upon the other. Dr. Mercier is emphatic upon the importance of the results to be obtained from post-mortem examinations, and insists that it is one of the prime duties of a Medical Superintendent to perform such examinations. As a result contingent upon this evasion of duty, the conduct of post-mortems in most large asylums is relatively valueless, and often the merest farce. In one asylum in which I served no post-mortems of any kind were performed (possibly the war was the cause of this), and none were compulsory except in case of an inquest. In the other asylum post-mortems were compulsory in all cases where the necessary permission had been given by the relatives.[1] But they were not performed by the Medical Officer in charge of the case unless he so desired. Neither was the Medical Superintendent ever present in my time. By an arrangement which, I am told, had been in vogue in this asylum for some years, these examinations (or at least the manual part of them) were usually performed by one of the male attendants in the presence of the Medical Officer, an arrangement of which, for reasons of health, I was personally only too glad to avail myself when necessary. As so performed they were, for all scientific purposes, practically useless. Were a pathologist appointed to all public asylums, or were even one of the Assistant Medical Officers selected for his special knowledge of pathology and a higher salary attached to the post, much good might result. In particular, were encouragement given to the younger men to devote themselves to the investigation of neurological and psychological problems, and were Medical Superintendents selected from such of these as had justified themselves by special study in these departments, a much higher standard of efficiency for this post would be forthcoming. As things are now, is it to be wondered at that the general

[1] This, of course, has always to be previously obtained.

standard of psychiatric attainment and neurological research is lower in English than in most Continental asylums, and that probably for one English neurologist of note, half a dozen French, German and Italian names could be quoted? In particular, is it to be wondered at that there are few acting Medical Superintendents of County Asylums in this country who are qualified by leisure, habit, inclination, and scientific aptitude to take their proper share in the advance of psychiatric medicine and the up-to-date treatment of the insane? There have been shining exceptions, of course, to this statement, in the names of alienists like Sir George Savage, Sir T. Clouston, Professor George Robertson of Edinburgh, Sir Maurice Craig, Dr. Stoddart, Dr. Bernard Hart, etc., and of neurologists like Sir F. W. Mott, Dr. Henry Head, and others, while of alienists and neurologists removed from us by death the names of Dr. Hughlings Jackson, Dr. Ferrier, Sir William Gowers, Dr. Maudsley, and Dr. Charles Mercier, must never be forgotten. But as long as Medical Superintendents in this country are allowed to regard themselves as primarily executive heads of their asylums, elected in most cases for life, and to delegate most of the practical medical work of the asylum to their subordinates, it is probable that they will still lay themselves open to the reproach of taking more interest in *drains* than *brains*, with the result that even the former, as we have seen, may not be up to date.[1]

[1] As an instance of the views which even County Councils may hold on the subject of asylum drainage, the following, taken from the *Worcestershire Chronicle* of February 12, 1921, may not be without interest. It appears that the Powick Asylum had long suffered from an impure water supply, resulting in continually recurring epidemics of typhoid fever. Recently there had been such an epidemic, with two deaths in twenty-three cases. In fact, so prevalent was the disease that it could only be kept at bay by inoculating practically all the patients and attendants. Yet when the sum of £20,000 was applied for to reorganize the asylum

We now approach a subject to which the attention of the reader is earnestly directed, and in which any evasion of medical duty on the part of the Medical Superintendent, fostered by the dual nature of his office, and almost inevitable under that system, exposes the patients to great hardships and often great injustice.

Probably of all the purely medical duties which the Superintendent has to perform one of the most important is that which concerns the discharge of patients. It is here that, in my opinion, not only the most radical alterations in the present system are demanded, but that a considerable readjustment in our views is necessary as to what degree of mental abnormality constitutes a sufficient reason for confining or detaining its possessors in a lunatic asylum.

The objects of such confinement, and of the deprivation of liberty which it involves, fall under three heads, which, in the order of their importance, may be thus enumerated: (1) To protect patients against themselves. (2) To protect the public. (3) To enable the insane to recover their mental health without undue delay and under the most humane conditions possible. The law recognizes the two first of these objects, but is quite silent about the third. Whenever the necessity of detaining a patient is referred to in the Act this action is spoken of as "expedient for the public safety," or "for the welfare of the lunatic," or, in one section of the Act (Sect. 74), because

drainage, a Worcester Councillor is reported as saying: "The asylum had been there a great many years, and *had not appeared to suffer from the existing water supply* (*sic*), so that the present was an inopportune moment for spending all that money on a new scheme." (Hear, hear.)

Another Councillor thought that "the question of spending £20,000 on Powick Asylum could be washed out." And "washed out" it apparently was by an amendment subsequently carried. One wonders what sort of "suffering" would have been necessary to convince the Councillor in question of the necessity for a pure water supply even to a pauper lunatic asylum.

the patient is "dangerous and unfit to be at large." So that what the law is chiefly concerned about is evidently the possible conduct of the patient, as affecting either his own safety or that of the public. Of the existence of any other object for detaining a lunatic, the Act, so far as my own reading of it goes, says not a word. But, for all practical purposes, it may be assumed that the presence of the third object enumerated above is everywhere admitted.

In all discussions as to the system of asylum administration, the value of asylum treatment, and the question of asylum reform, these three reasons for the admission and detention of the insane in public asylums should never be lost sight of. According as they fulfil or not these three conditions, all systems for the public or private detention of lunatics must finally be judged. It is not enough merely to confine lunatics in asylums for their own protection and the protection of the public, which was all that public sentiment demanded up to the middle of the last century, and which is all, apparently, that the law demands at the present time. Humanity—that is, public sentiment—has so far progressed since that date that it demands now that this confinement shall be as humane as possible, and shall be accompanied by an organized method of remedial and curative treatment. If we are obliged for reasons of public policy to deprive the insane of their personal liberty, we are bound in honour to do everything in our power to expedite their recovery. To this, when once the patient is within the asylum, every other object for which an asylum exists should be subordinated. Thus, not only should our public asylums be well built and wisely organized, with all the improvements that modern systems of housing and sanitation have made possible, but we should be at constant pains to improve upon these methods by comparing them with those in vogue in other countries. Every effort should be made to alleviate the unavoidable

hardships of the lunatic's lot, and in particular no more interference with his personal liberty should be practised or tolerated than is necessitated by the objects which his confinement primarily aims at. With this aim it is essential that every advantage should be taken by the Medical Staff in asylums for the scientific study of insanity, and an organized system of remedial treatment should be founded upon it. Only in this way can we honourably discharge our obligations to the insane and compensate them for that loss of liberty which we have been obliged to inflict upon them. Nor should we deprive them of that liberty for a single day longer than is necessary.

The question of a patient's fitness for liberty is thus one of the most important, as it is one of the most difficult, with which a Medical Superintendent of an asylum has to deal, and his motives when dealing with it should be above suspicion. They should be concerned chiefly with the first two objects in accordance with which the patient was originally detained, viz.: (1) Is he a danger to himself? (2) Is he a danger to others? And a consideration of these two objects should be combined with that of the third: (3) What is the treatment most likely to conduce to his recovery? If the patient is neither dangerous to himself nor to others; if he is capable of earning his living under proper supervision, or has relatives who will support him and be responsible for his behaviour; if, moreover, his mental condition is likely to deteriorate under continued confinement and to improve under release, then, whatever his eccentricities or the state of his mental faculties, he should provisionally be restored to liberty. Cases, of course, constantly arise when there is considerable doubt whether any of the above questions can be satisfactorily answered. And it is in just those cases that a Superintendent's motives in making his decision should be grounded upon what he thinks best for the patient, with a due regard for his and the public

safety, and should be absolutely unbiassed by the fear of any damage to his own reputation which may result from a mistake of judgment. His only duty is to the patient and the public; he has none to his own reputation. If he is an able and conscientious man, and has taken every pains to make himself personally acquainted with each case that comes up for discharge, if in a word he is fit for the important and responsible post he occupies, his own reputation can be left to take care of itself. And yet it may unfortunately sometimes happen that a Superintendent does not act in this way. He may be guided in doubtful cases by the effect which a mistake in judgment will be likely to have upon *himself*, his future prospects, and even his retiring pension. And the more he has neglected to make himself personally acquainted with his patients, the more likely is he to be actuated by these purely self-regarding motives. His consciousness of his medical shortcomings warns him that he cannot afford to take any risks, however the fortunes of the patient may suffer. The temptation for such a Superintendent so to act is no doubt a strong one, and may be justified to himself by many specious arguments. When a man has had a record of long and (officially) unblemished service, especially when this service is drawing to a close, he is loath to "spoil" it by taking any chances of making a mistake. One of the Superintendents under whom I served was quite frank in the matter. He told me once, when I was urging the claims of one such doubtful case to probational discharge: "I have been a Superintendent for a long time now, and have never yet got into trouble with my Board or the Commissioners. The facts may be as you say, but I am taking no risks. I have my own reputation to think of." Not many Superintendents would be so cynically frank as that; but few, I fancy, would deny, in moments of conscientious self-examination, that they have never acted in accordance with these motives. But whether this is so or not,

it is obvious that the more a Superintendent sees of his patients the less risk will he run of doing injustice to their claims or his own reputation.[1]

[1] The question of what patients are and what are not fit subjects for detention in a lunatic asylum, not only raises the subject of what constitutes certifiable insanity, but the whole question of asylum organization and management, and the asylum treatment of the insane. To decide this question of fitness is one of the most difficult tasks that falls to the lot of alienists and medical men generally. Were our public asylums constructed and administered with a sole view to the comfort and happiness of their inmates, and to the most humane and rational methods of remedial treatment and cure, a medical man would have less hesitation in certifying a patient who was doubtfully insane (and there are many such), as a Medical Superintendent would have less hesitation in detaining in an asylum a patient of whose fitness for discharge he was equally uncertain. Especially, as we shall see in a later chapter, were it legal to admit incipient cases of insanity into public asylums without certificates, as they can even now be admitted into private asylums and registered hospitals under the "voluntary boarder" system, the position of a medical man would be far less invidious and difficult than it is. This question of the treatment of incipient insanity is a more important one, and nowhere is a reform in our lunacy legislation more urgently needed. I deal with it more fully in Chapter XI. As things are at present, a medical man is often as loath to certify an early case as insane as a humane asylum Superintendent is loath to detain any longer than necessary a patient who may yet not have completely recovered. And this for the same reason, viz. that under our present system of asylum construction and organization, asylum life may be the worst possible method of treating either case. We run the risk of "manufacturing a lunatic," in Dr. Maudsley's words, in the one case, and of indefinitely retarding a patient's recovery by continued detention in the other. Nothing better illustrates the difficulties which confront a conscientious Superintendent when considering the discharge of doubtful cases (the question of their admission is not in his hands), as nothing shows more clearly the importance of his devoting his chief attention to his strictly medical duties. For the lack of this, it is my contention that many patients are detained in our public asylums who are fit for their liberty. In my Note Books are notes of six patients whose discharge I had long regarded as considerably overdue. I was successful in getting four liberated, and as none of them have been re-admitted

But for such selfish timidity there is really no excuse, for it is due in nine cases out of ten to sheer neglect of medical duty. This timidity is often condoned to the Medical Superintendent's conscience on the plea that, though a patient may show great improvement while under asylum control, he may break down when restored to liberty. Under such a plea, as Dr. Mercier well says, it is difficult to see how any patient would ever get his liberty. How many doubtfully insane persons may be confined in asylums at the present moment under this plea it is not pleasant to contemplate. Yet unquestionably, when any doubt exists, and the first two considerations I have mentioned are reasonably fulfilled, the patient should be given the benefit of it. I would be disposed myself to go even further than this, and to say that it is better that one doubtfully sane person should have his liberty than that one doubtfully insane should be deprived of it, on the principle, recognized by our criminal law, that it is better that an actually guilty man should go free rather than that a possibly innocent man should be punished. But, of course, there is here no question of setting an undoubted lunatic at liberty. There is merely the question of a doubtfully sane person being discharged *on trial.* The very fact that *discharge on trial* is a recognized method of treating such cases strengthens my argument, which is that all doubtful cases should be given provisional liberty when it is reasonable to suppose that they will not be a danger to themselves or others, and when their friends are willing to be responsible for them. Not that even this last condition is essential or should weigh against the others.

after a lapse of more than two years, my persistence would seem to have been abundantly justified. The remaining two cases were equally, if not more, deserving, and I am glad to hear from a reliable source that one has lately been discharged to the care of friends," and the other is "likely soon to have his liberty." In my opinion, both should have had it years ago.

For it not infrequently happens that the relatives of a pauper patient are anxious to keep him in the asylum even after he is fit for discharge, and on the plea that they are "afraid to have him at home" often succeed in so impressing the Medical Officer in charge of the case as to prevent him, if he is a timid man, from sending the patient up for discharge. Especially is this the case when the wives of such patients have got tired of them or have contracted other "ties." Of course, no conscientious Superintendent, *who knew the patient well and had studied his case,* would be put off by such a plea, if the case was otherwise fit for discharge. But when it is the habit of a Superintendent to leave this matter entirely to his subordinates, and never to acquaint himself with any patient until he is sent up for discharge, it is only too likely that this plea will have undue weight. But that this plea should have any force at all is one more argument for a radical alteration in our divorce laws. Were insanity, lasting a certain number of years and presumably incurable, included among the legal grounds for divorce, as Lord Gorell's Commission and the present Bill before the Houses of Parliament advocate, it would no longer be an incentive for the husband or wife of a lunatic to keep an undesirable life-partner in a lunatic asylum by every means in their power, including lying and false witness, as the sole method of being rid of their marital obligations. I am no advocate for relaxing the existing divorce laws merely to suit people's convenience; but if chronic and presumably incurable insanity is not a just, as it is certainly an eugenic, ground for divorce, it is difficult to say what is. Whether such radical changes as are contemplated in Lord Buckmaster's Act would compensate for the disadvantages which may be urged against it, I am not sociologist or statesman enough to decide. But that some such changes are to be welcomed on the ground of social policy I have no doubt. It may seem hard that the victim of mental

disease, who may subsequently recover, should suffer so grievous a personal and social penalty as divorce for what after all is a grave misfortune, but no fault; but it is equally hard, and socially perhaps more productive of evil, that a sane man or woman should be tied for life to a partner who is incurably insane. The personal hardship is probably about equal in either case; but from the social and eugenic point of view, the advantage seems to me all on the side of reform. For married relations to be resumed between two people, one of whom had only recently recovered from insanity, is to expose the wife, should she be the one, to a recurrence of her mental malady, and in any case to render possible and even likely the birth of tainted offspring. Where some hardship must exist, it seems wiser and more humane to limit it to the existing generation than to hand it on to those that follow.

I have thought it better to refer to this particular legal reform here, as well as in the chapter devoted to lunacy law and other reforms, because, though it affects lunatics, it is not specially concerned with lunacy law, and because it gains more weight by being discussed in the chapter to which it properly belongs.

The question raised in the last paragraph inevitably suggests the cognate question as to how far the discharge of the doubtfully recovered married insane, who are still within the child-bearing and procreative ages, can be justified as a matter of public policy, even though from the legal and psychological standpoints they may be entitled to their liberty. This question needs the most careful consideration, and is among the most difficult that a Medical Superintendent has to deal with. Every Medical Officer of an asylum knows that when a married female patient within the child-bearing age is discharged to the care of her husband, the probability is that she will again become pregnant, with the added likelihood of her returning to the asylum immediately before or after the birth of the child. Her temporary release will thus

have done her little good, and may have done the community distinct harm, in that it will have resulted in adding one more to the number of potential mental defectives. It may be laid down at once, as a rule to which there are no exceptions, that no weak-minded or imbecile young woman, married or unmarried, should be allowed such liberty as may result in her giving birth to offspring. Not that imbeciles of either sex are proper subjects for confinement in an asylum. These unfortunates are really out of place in such institutions, and when their relatives are unwilling or unable to take charge of them, should be segregated in special colonies, like epileptics, and not allowed to mix with their fellows at all. But wherever they are detained, there they should remain for the rest of their lives. Many of them can be quite usefully employed, and they are all capable of living fairly happy and useful lives. It is nothing short of a public scandal that weak-minded women and girls, who form so large a proportion of the workhouse population, and from whom the lower ranks of the prostitute class are so largely recruited, should be constantly discharged from these institutions, only to return to them after having given birth to a child. It is no uncommon thing for one of these unfortunates to have half a dozen illegitimate children in the brief intervals of her incarceration in various workhouses. What to do with these poor creatures is a difficult social problem. A growing body of medical opinion is in favour of their being painlessly sterilized, especially since it is now known that this can be done without their being subjected to any mutilating operation. But whether this action is approved or not, one thing is certain: in their own interests and those of society they must not be allowed to become mothers. My own view is as stated, viz. that they should be segregated in special communities, not, as is now so frequently the case, in public asylums, where they only take up room that could be more usefully allocated.

A similar difficulty confronts the Medical Superintendent of an asylum when the question is raised of discharging an early, or remittent, case of general paralysis of the insane. This disease, which attacks men much more frequently than women, is invariably fatal, and usually within three or four years. But its subjects are mostly young and otherwise healthy men, and it is liable to marked remissions during which the patient may be, for all practical purposes, quite well. If they are women, and past the child-bearing age, there is no harm in discharging them during such remissions, if they can be properly cared for. With men it is different. There is no means of compelling a married man not to resume marital relations, and many who are thus discharged do in fact resume these relations. And as general paralysis is invariably associated with a syphilitic taint, the resulting offspring, should such there be, may inherit a tendency to both the mental and physical disability. For this reason I am strongly of opinion that no married general paralytic, still sexually competent, should ever be discharged from an asylum unless his wife is past the child-bearing age. His return is certain in any case, and no risks should meanwhile be run.

We have now to see the conditions under which discharges took place in my experience and during my term of office. I am, of course, unable to say whether they obtain in all public asylums, but for the sake of the patients I profoundly hope they do not. The first thing that struck me was the anomalous and altogether unsatisfactory manner in which this important business was conducted. The reader has realized how great is the responsibility devolving upon a Superintendent, and how important it is that he should be in a position to adjudicate wisely upon this most difficult question. It is obvious that no wise and just decision is possible in many cases unless the Superintendent is personally acquainted with the patients whose claims he is called

upon to consider. No mere reading up of the history in the Case Books five minutes before the interview, or falling back upon one's general knowledge and previous experience of insane types, will take the place of this personal acquaintance. The more experience and knowledge the Superintendent has, of course, the better; but the fact remains that a Superintendent who persistently and for many years ignores his medical duties is not likely to retain much of either. A hospital physician or surgeon who seldom or never went into his wards except to chat with the nurses or to see that they were engaged on their duties, who never studied his cases personally or consulted with his colleagues, and whose time was chiefly taken up with planning alterations or repairs to the buildings, would soon become rusty and his knowledge out of date, however capable he may have been on his first appointment. And mental disease is certainly as complex and difficult a subject as physical disease, and does not conform so readily to type. It must be remembered, besides, that in deciding upon the discharge of a patient from an asylum the Superintendent has not only the interests of the patient to consider, but the interests of the public as well. He must take into consideration also not only the present, but the past and the probable future of the case. And this he cannot do in many cases as the result merely of a ten minutes' interview with a patient whom perhaps he has never seen before. It is not fair to himself, and it certainly is not fair to the patient. One would have thought, too, that upon so important a question as the discharge of a patient, the Superintendent, following the custom of hospital routine, would have taken advantage of the opportunity of consulting with his medical colleagues, especially with the Medical Officer who was in charge of the case, and who presumably knew, or ought to have known, most about it. But this is just what in my experience never happened. The Medical Officer could proffer his own views,

of course, which might or might not be accepted, but he was never systematically consulted over the patient, and he was never present at the final interview. The reader may imagine, perhaps, that this was due to the fact that we locum tenentes were only temporary, and, so to speak, makeshift officers, and that the permanent Medical Staff was otherwise treated. I was assured, however, by a Medical Officer who had been in office for over twenty years in one asylum that the same custom had been in vogue throughout the whole period of his official life. The Medical Staff were always treated by this particular Superintendent as though their opinions were of no importance.

During the interview aforesaid, which possibly lasted only a few minutes, the Superintendent was supposed to find out the exact state of mind of each patient in turn who came before him. To the patients themselves, of course, the interview was of crucial importance, for upon their behaviour and the quality of their answers to the questions put to them depended their chances of liberty. Great tact and sympathy is required to elicit satisfactory information from patients on these occasions, for, naturally enough, a nervous subject may not do himself justice. Most Superintendents have had a large experience of lunacy, and no doubt regard themselves as fully qualified to decide upon the merits of the most difficult case without any extraneous aid and information; but they are only human after all, and no amount of general knowledge and previous experience can take the place of personal acquaintance with each individual case. I hope the reader will not misunderstand me. I do not suggest that it is the duty of the Medical Superintendent to be as conversant with the case of each patient as the Medical Officers. That is not to be expected. But I do suggest that previous to the discharge day he should call for a list of all the patients who are coming up, and should personally examine these cases in the presence of and in consultation with the Medical Officers

in charge of them, even though the latter were not present at the final interview. This would not only ensure justice being done to the patient, but if the Superintendent were a competent man would have a very beneficial and helpful effect upon the younger Medical Officers, and would tend to keep both them and the Medical Superintendent up to their duty. That the judgments of a Superintendent who forgoes this obvious duty of making personal acquaintance with his patients and of consulting with his colleagues about their discharge are liable to be at fault, I had many opportunities of proving during my term of office. But though I assert nothing which I am not prepared to prove, and am careful not to lay myself open to the charge of making unsupported and *ex parte* statements, it is obvious that in a book of this sort, intended for the general reader, to cite cases in evidence of this contention would be to raise the whole question of what constitutes the type of insanity that is properly detainable in a lunatic asylum, and in effect to ask the lay public to adjudicate upon one of the most difficult problems of morbid psychology. This of course would be absurd. I must content myself therefore with the general statement that in my experience many cases are detained in our public asylums for much longer periods than are necessary owing to the preoccupation of the Superintendent with purely executive work and consequent lack of personal acquaintance with his patients and his disinclination to consult with his Medical Staff. If to this is added the fact that the discharge of many patients is delayed owing to the obstacles set up by the unwillingness of their relatives to receive them, fortified often in the cases of married people by deliberate lying and false witness; the neglect of a recognized system of "parole" and "ticket-of-leave," such as obtains with regard to prisoners; the want of half-way discharging wards; the imperfect facilities for the treatment of incipient insanity; the lack of proper safeguards in the

certification of the insane owing to the recognized ignorance of psychological medicine of most general practitioners, etc., to all of which I shall refer more fully in the concluding chapters, it will be obvious to the reader that cases of improper or unnecessary detention may be more numerous than he has hitherto imagined. I bring no charge, of course, against any Superintendent of wilful detention from malicious motives of patients who are fit for discharge; my criticism throughout this book is directed against a system which, through permitting and even encouraging a Superintendent to subordinate his medical to his executive duties, inevitably results in injustice being done to individual cases, not of malice prepense, but through sheer indifference and preoccupation. And I am persuaded that many Medical Officers on the Permanent Staff of our County Asylums would support my contention. The general public has long been suspicious of the veil of mystery which hangs over the treatment of the insane in this country, and far as I am from suggesting that their worst suspicions are justified, and that sane people are deliberately confined in asylums owing to the machinations of designing relatives and the venality of officials, I am persuaded that, owing to the facts I have stated, many persons are now detained as insane who, on legal and psychological grounds, are fit for their liberty. I have no knowledge of what goes on in private asylums, but should not be surprised to hear that similar abuses were current there, and with probably less excuse. This may sound like, and no doubt is, a criticism of the efficiency of the Board of Control, but the reader will have gathered from statements previously made, and which will be amplified later, that in my opinion the constitution of this body, able, hard-working and conscientious as I believe it to be, stands in need, like so much else in our asylum administration, of radical reconstruction and reform.

Before closing this chapter it will be as well, perhaps,

if I state shortly but clearly what the law is in this matter of the discharge of patients. I have said that the medical responsibility for these discharges rests chiefly upon the Medical Superintendent, and for all practical purposes this, no doubt, is the case. But in law the final responsibility rests upon the Visiting Committee, or upon any two or three of its members whom they may elect to represent them. It is these members who sign the order for discharge, and no such order is legal unless so signed. The Lunacy Act of 1890 is quite definite upon this point. It enacts (Sect. 77) that "Any *three* Visitors of an asylum may order the discharge of any patient detained therein, *whether he is recovered or not*." And again, "Any *two* such Visitors, with the advice in writing of the Medical Officer, may order the discharge of any person detained in the asylum."

What usually happens is this: The Visiting Committee appoint two of their members as a Discharging Sub-committee. The Medical Superintendent examines the cases sent up to him by the Medical Officers, and recommends the discharge of such of these as he thinks fit. These selected cases then come before the Discharging Sub-committee, who ask them a few questions, and then sign the order for their discharge. Only in the rarest instances does this Sub-committee take upon itself to dispute the advice or act contrary to the finding of the Medical Superintendent, as, in such a purely medical matter, it is difficult to see how it could. That the final decision should be left in the hands of a lay Committee may seem strange to the reader, but follows naturally from the fact that the Visiting Committee are legally responsible for the detention of all inmates of pauper asylums, and can even, as we have seen, discharge any such on their own responsibility and without consulting the Medical Superintendent. And since, in cases of improper detention, they would themselves be liable to prosecution, it is necessary that the final word should be with them.

CHAPTER VIII

THE ASSISTANT MEDICAL STAFF

HAVING considered the case of the Medical Superintendent, it is time now for me to examine another department of asylum administration, which, though not so important, intimately concerns the patients' welfare: I mean the department of the Assistant Medical Staff. After that we will consider the case of the male and female attendants, which is only little less important than either.

Radical as are the changes necessary in the principles of asylum administration, in no department save that of the Superintendent is reform more urgently needed than in the status, remuneration, and duties of the Assistant Medical Officers. These young men, as a rule, take up their appointments almost immediately after leaving the hospitals, and without any previous asylum experience. In most cases they have not even held any of the junior hospital posts, such as those of House Surgeon and House Physician, and this fact has an important bearing on the matters shortly to be discussed. Though their probable intention is to make asylum practice their life-work, there is not at present any obligation that they shall hold a diploma in Psychiatric Medicine. They have probably attended in their hospital course a few lectures on psychiatrics and forensic medicine, but they come to the asylum practically raw to their work, and must gain their experience as they go along. This is one of the great defects of our medical education, and is probably unique in the system of medical appointments.

These appointments, like that of the Medical Superintendent himself, are, moreover, in the hands of the Asylum Committees, and are subject to all the well-known abuses, such as favouritism and wire-pulling, to which such appointments are liable. Nor, until the whole medical service of our asylums is taken over by the State, is it easy to see now such abuses can be avoided. These same bodies also fix the amount of salaries paid and frame the rules which govern these appointments and to which the Medical Officers have to conform (Lunacy Act, 1890, Sects. 275, 276). It is true that these rules, before becoming legally enforceable, have to be submitted to the Secretary of State, by whom they must be approved, but I have never heard of any Government interference in the matter. The consequence is that the Assistant Medical Officers of public asylums, like the Medical Superintendent, are servants of the Asylum Committees, and have no duties, save those of ordinary citizens, to the State, and can be dismissed at the pleasure of these Committees, without (so far as I interpret the Act) any power of appeal.[1] The same applies to all the other officials employed by the asylum. The question as to the wisdom of conferring such powers upon the Asylum Committees will be discussed later. But though nominally and legally under the jurisdiction of the Visiting Committee, the Assistant Medical Officers are in actual effect almost entirely under the jurisdiction of the Medical Superintendent. It is he who in most cases is consulted in their appointment and dismissal, and his word carries, as is natural, very great weight. It is he also who apportions them their duties and practically dictates the disciplinary rules to which they have to conform. If they succeed in pleasing him, they can mostly afford to ignore the Committee. If they are so unfortunate as to incur his displeasure, the Committee can, or rather will, do little to help them. For all practical

[1] The case quoted in the note to Chapter VI illustrates a hardship that may result from such arbitrary action.

purposes their comfort and happiness, as well as their prospects of future advancement, depend upon the goodwill of the Medical Superintendent. Much of this, of course, is inevitable. The Superintendent must be master in his own house. However obnoxious to the asylum welfare may be, and undoubtedly is, the system which permits the Superintendent to combine in his own person the offices of Medical Superintendent and Executive Head, his disciplinary authority over the whole asylum personnel cannot be taken from him without entailing serious consequences. There cannot be two captains with equal and possibly conflicting authority on the same ship. None the less, I believe that the Assistant Medical Officers should be given a much greater, though still subordinate, share in the strictly medical government of the asylum than they at present have.[1] Especially, as I have insisted in the last chapter, should they have official recognition in the case of discharges of patients, though without derogating from the ultimate and necessarily supreme authority of the Superintendent in this matter. They should also be allowed more personal liberty.

This increase of personal liberty, indeed, should not be confined to the Medical Staff, but should include the patients and attendants as well. In fact, it is my opinion that we should renew and revise our whole conception of the treatment of insanity and the conduct of our public asylums. Rules and regulations there must be, of course, for all the officials as well as the patients in these institutions, and these rules must be observed, and their observance, if necessary, enforced. But it should be our aim to make asylums less like the prisons they are, and more like the mental homes they ought to be. Lunatics are not criminals, and asylum attendants

[1] On page 19 (Part I) of the Sixth Annual Report of the Board of Control, published after this book was written, the Commissioners quote a letter written to the Minister of Health, embodying many of the recommendations suggested in this chapter.

are not jailers, and asylum doctors should be subject to no more vexatious restrictions than are hospital doctors, and should enjoy as much liberty and consideration.

There are many petty rules and regulations in all asylums the observance of which should be left, and might safely be left, to the discretion of a conscientious Medical Officer. But such matters as the duration and number of their annual holidays should be fixed by law, and not left to the whim or convenience of the Superintendent or the discretion of the Committee, and so many days' occasional leave should be allowed without loss of pay. The power of appeal to a properly constituted body against wrongful dismissal should also be accorded them by Statute.

Probably the greatest cause of complaint among asylum Medical Officers is the lowness of their salaries. These before the war were entirely inadequate, a Junior Medical Officer receiving in many cases not more than £150 a year and his keep, rising by £10 a year to the munificent figure of £300 to £350 a year. From this a yearly sum was deducted under the Superannuation Act. The war will no doubt alter all this, but it is the contention of this book that matters of this importance should not be left to the chance happening of events. In the reconstruction of the medical organization of this country which is destined to take place under the newly formed Ministry of Public Health, it is to be hoped that asylum administration will be included, and that not only the salaries of asylum Medical Officers, but the number of patients contained in each asylum, and the proportion of doctors and attendants to patients, will no longer be left to the discretion of Asylum Committees, but will be regulated by law. Only in this way can the ends of justice be attained, and the public treatment of insanity placed upon a humane and scientific footing.

In consequence of the lowness of their salaries few Medical Officers are in a position to marry, even if the

asylum regulations permitted it, which is seldom the case. Most Medical Officers have to sign an agreement on appointment that they will not marry except on pain of dismissal, and we can imagine how hardly this may press in individual cases.[1] Actuated by the same spirit, few asylum authorities make provision on their premises for married Medical Officers. This, from the point of view of asylum efficiency, is a very short-sighted policy, and results in the best men not accepting, or in a few years resigning, asylum work. To attract this class provision should be made in all large public asylums for at least the Senior Medical Officers on the male and female sides being married men. Most of these officers have attained the age of thirty-five before occupying this position. A minimum marrying age (say thirty) might be fixed, and all Medical Officers who have reached this stage should be allowed to marry, if they decide to stay on the Medical Staff. It would lead to medical men making asylum practice their life-work, instead of being the mere stop-gap it often is at present, to be given up just when their experience has become of real value to the community. Not only would marriage stabilize the prospects of the Junior Medical Staff and add to the interest of their work, it would add enormously to the health and happiness of their lives, and so indirectly to the happiness and welfare of those under their charge. No one who has not experienced it can imagine the deadly dulness and monotony of an unmarried asylum doctor's life. No wonder some of them take to drink or drugs, or indulge in still more sordid pleasures. To live among lunatics all the year round, with only a fortnight's annual holiday, with few social attractions or diversions (for most asylums are far in the country and at a distance from any large town), with restricted intellectual companionship, and little official inducement to take any scientific interest in their work, with poor salaries, and no chance

[1] *Vide* note to Chapter VI.

of promotion or facilities for marriage until they have reached middle age, is an experience calculated to test the stoutest courage, and sour the most cheerful disposition. It reflects the greatest credit upon asylum Medical Officers that, with all these disadvantages to contend against, they should as a class set so high a standard of professional conduct, and contribute such a solid body of scientific work to the discussions of the societies and the pages of the journals devoted to psychological medicine. That much more advantage might be taken of their opportunities for the study of psychological problems is, no doubt, true ; but this is largely the result of the administrative system which fritters away so much of their time upon needless clerical work, rather than of any intellectual apathy on their part.

I have already described how the Medical Officer's morning is spent, and I will not weary the reader with a repetition of this part of the day's work. After lunch, we were generally free till four o'clock, when it was necessary to interview any of the patients' visitors who wish to see them. The intervening hours provide the necessary opportunity for exercise and social relaxation, when the latter is obtainable. In summer, such games as tennis and golf are usually within reach, but in winter and wet weather the lack of opportunity for indoor exercise was very much felt in the two asylums in which I worked. A covered racquets or tennis court would have been a great boon, especially for the younger men. Nothing would tend to make a young English Medical Officer more contented with the restrictions and monotony of asylum life than facilities for indoor exercise in winter, and some means to that end should be a *sine qua non* of all public asylums. A billiard-room is all very well for the evenings, but a billiard-room does not provide enough strenuous exercise for a young and healthy man. The same argument applies with equal force to the younger attendants, and even more to the healthy and active

patients themselves. Outdoor games, like football and cricket, are encouraged in most public asylums for the attendants and the patients who can safely take part in them, and when so encouraged, statistics prove that the recovery-rate among the latter invariably goes up. Yet no football or cricket was ever played in the asylum in which I served most of my time, though I have known some of the junior clerks indulge in a little cricket practice in the summer evenings. The war, no doubt, and the consequent diminution in the number of attendants was largely responsible for this. But not altogether. When I once asked an attendant why football was not played in this asylum, I was told that it had not been played for some years before the war. It appears that an attendant had once broken a leg at the game, and the Superintendent had forthwith given orders that no more football was to be played. So that because an attendant had once had an accident at the game, the whole asylum was debarred from playing football.

The visiting hours at this asylum were from 2 to 4 p.m., and there were five visiting days in each week. The exceptions were Wednesdays and Sundays. The Medical Officers were supposed to be on duty at 4 p.m. to interview such visitors as wished to see them. But no one was allowed to visit more than once a fortnight the same patient, and no patient was allowed more than two visitors at a time. Saturday, being a half-holiday, was the most crowded day, and there were then sometimes a couple of hundred visitors to be attended to, and attendants and doctors were kept busy. Irksome though these visits were, from a Medical Officer's point of view, and often of doubtful advantage to the patients themselves (many of whom were apt to be more troublesome and restless afterwards), it is difficult to see how they could be curtailed in justice to the patients and their friends. But one reform was certainly possible, and that was to limit the medical interviews to two, or at

most three, days a week. In that time all the necessary medical questions could be asked and answered, and all the required information regarding family histories obtained. During these interviews much frank criticism was often expressed as to the methods of our asylum administration, and a good deal of light was thrown on the views held by the public upon the treatment of the insane. Much of the criticism expressed was, of course, misdirected and misinformed, and due to ignorance. Thus it was a commonplace for a Medical Officer to be roundly abused for keeping such and such a patient in the asylum. Insults and threats were even forthcoming at times from ignorant and exasperated relatives, and these had to be sternly dealt with. What inducement a Medical Officer could have for keeping a sane person in a public lunatic asylum never seemed to occur to them. Not that improper detention is, as we have seen, impossible, under the methods of administration that now exist. But, as a rule, the more insane the patient, the more sure were his friends of his fitness for discharge. On the other hand, it sometimes happened that the more fit a patient was for discharge, the more strenuously it was opposed by those most closely related to him. But these were not usually blood-relatives. But just as it is possible, in my opinion, for a person to be wrongfully detained in an asylum under the present system, it is equally possible for a person to be improperly admitted, and occasionally through his own connivance. It is not unknown for a certain number of undesirable persons and those wanted by the police to gain admittance to lunatic asylums by feigning insanity, from whence after a short period of incarceration they are once more set free to resume their depredations upon society. Two such cases occurred in my own experience. The first case was undergoing a term of imprisonment, and while serving his sentence had managed to get himself certified as insane and transferred to the asylum. It did not

take me long to assure myself that he was malingering, and soon afterwards, to his great disgust and chagrin, I procured his discharge, not to the outside world, as he evidently hoped and expected, but back again to prison.

The second case was a deserter from the army, who had been caught, and was undergoing military punishment. He had been in an asylum before, and was sufficiently familiar with the commoner features of insanity to be able to feign them with sufficient success to be certified. He had been in the asylum for nearly a year when I took office, and was beginning to get tired of it. I watched him carefully, and soon had little doubt of his sanity, which was confirmed when I found out more about him. He was a very intelligent man, but a bad character, and had been a heavy drinker. He tried hard to get me to send him up for discharge, which I fully intended to do; but he over-reached himself. Letters used to come to me from a "friend" of his outside, bearing testimony to the excellence of his character, and promising to look after him when he was given his liberty. Something about the letters aroused my suspicions. I obtained a specimen of the man's handwriting, and found it was identical with that of his "friend's" letters. He had written them himself and got one of the visitors to post them outside. As a punishment I kept him back another two months, and gave him my reasons. He was very disgusted, but not the least ashamed. I found out afterwards from the supposed friend, who really existed, and to whom I wrote, that the man was an out-and-out blackguard. However, he was not insane, and I shortly procured his discharge.

These two cases are instructive. If this medical ignorance can exist in the case of army surgeons and prison doctors, we may be quite sure of its existence in the case of the general practitioner who, as a rule, has far less experience of borderland types, especially in connection with drink and criminality. It is a common-

place for Medical Officers of asylums to have to admit patients whose certificates prove that the medical men attesting them have very imperfect notions of what constitutes certifiable insanity. Several instances have occurred in my own experience in which the certificates were so ineptly and inaptly worded that they had to be sent back to be amended, and in two cases it was found that the patients were not insane, and were within a few days restored to their friends on the order of the Commissioners. I deal with this question of general medical ignorance more fully in a later chapter.

An amusing instance of the improper filling in of medical certificates is given by the authors of that excellent handbook *The Insane and the Law*, from which I have already quoted. A medical man was called in to certify an insane person whose delusion was that his feet were a hundred yards long. The medical statement dealing with this delusion simply contained the words "fancies he has large feet." The certificate was, of course, sent back, with the suggestion that the least that could be accepted in such a case was the additional statement "the same being untrue." It happened that the same practitioner had, on another occasion, to certify a patient who was violently maniacal, and during his ravings used the foulest language. The practitioner, being entirely unblessed with a sense of humour, and mindful of the admonition given him in the former case, duly certified these facts, and added as an example of them, "Called me an infernal old fool, *the same being untrue*!"

After interviewing the visitors we Medical Officers (to return to my own experiences) were at liberty till six o'clock, when the evening round of the dining-hall and wards had to be made. This was a much shorter affair than the morning round, and did not take more than ten minutes or a quarter of an hour. The chief matters to be decided were the sleeping arrangements for the

night and the prescription of sedative draughts. A few teeth might be extracted then, but as a rule dental extractions were performed after the morning round. After tea and midday dinner the better behaved and more reliable male patients were allowed to smoke and play cards in the dining-hall, a much esteemed privilege, and this was an opportunity which was often utilized by the Medical Officers for any interviews or conversations that were desirable with individual patients. Little privacy, however, was possible on these occasions, and the absence of any private room in which these interviews could be held has already been adversely commented upon.

The dinner hour for the Medical Staff in this asylum was at 6.45 and lasted till 7.30, when the house servants went off duty. After that the Medical Officers had the rest of the evening to themselves, but, as we shall see, it was far from being a period of uninterrupted leisure. At 10.30, or as much later as they liked, the night round of the wards had to be made. Few more pathetic sights exist than the wards of a lunatic asylum at night. A hospital ward is sad enough, but there is a gloom and melancholy about sickness or injury of the mind that is absent from all disease or misfortune of the body, however grave the latter may be ; and this gloom is accentuated at night. For we feel instinctively that it is the mind that makes the man, and no physical ill-health or injury as such can derogate from what is man's essential dignity and prerogative. But with disease of the mind it is different : a madman may be not merely a mindless animal, he may be at times more degraded than a wild beast. *Corruptio optimi pessima.* But sleep, at any rate, we think, should restore some features of the humanity that in waking life is in abeyance, and throw the mantle of oblivion over the miseries and degradation of the day. Yet for many of the sleepers the existence of this respite is more than doubtful, for

their dreams are obviously troubled. Sighs and groans are frequent, and there is much restlessness and often loud cries, interspersed with rambling and incoherent speech. And these dreams of the insane, of what do they consist and what is their nature? We have seen that there is reason to suppose that madness itself is a species of disordered waking dream, in which the dissociation of personality so familiar in dreams is a conspicuous feature. Were the insane sufficiently intelligent to remember and describe their dreams, a field for very interesting investigation might be opened, and much light might be thrown upon the problems of insanity. For we know that dreams, unlike most waking mental processes, tap the subconscious mind, which is probably the seat of most forms of mental disorder, and provides the chief material for the science of the psycho-analyst. The dreams of even sane people are frequently absurd and irrational, but that no dream is really without psychological meaning is becoming increasingly evident, while some have even helped to disclose the presence of unsuspected disease. So that it is quite possible that in dream-analysis may yet be found the key to some of the problems of insanity. The insane, like the sane, dream constantly, and their dreams are often of a terrifying nature, especially those produced by acute mania and delirium tremens (alcoholic insanity). In fact, the insomnia which is so frequent and painful a feature of the two latter affections may be regarded as a form of waking dream, so that their whole mental state may be likened to one continuous and horrible nightmare. In passing through the wards, and listening to the cries and moans and the restless tossing of the patients, I have often been reminded of the description of the lazar-house in Milton's well-known lines:—

> Dire was the tossing, deep the groans,
> And over them triumphant Death his dart
> Shook, but delayed to strike.

In that "delay" lies the pathos of many of these cases.

It will be seen from the above account of a Medical Officer's day that our time was fairly well occupied, especially when it is remembered that there were some two thousand male and female patients in the main asylum, and only four Medical Officers in charge of them. But in the account I have just given there are two very important items which have been left out, viz. the reception of new patients and the writing up of the Medical Case Books. The reception of new patients took place at all hours of the day, but most frequently in the afternoons. This was generally the duty of the Senior Medical Officer on either side, but in his absence it devolved on the Junior. It was for this reason that one or other Medical Officer on either side had always to be on duty, for no patient can be admitted except by the Medical Officer on duty or the Medical Superintendent. An admission was a somewhat lengthy affair, and took from half to three-quarters of an hour. The Reception Order had in the first place to be carefully scrutinized, for often mistakes in names and dates are made; or it is otherwise imperfectly filled up, which may render the order invalid and the reception of such patient illegal. If found in order, the patient was examined by the Medical Officer on duty and taken to the Reception Ward, as previously described. Sometimes as many as eighteen or twenty patients were admitted on the male side in one week, and this, as may be imagined, meant a large amount of additional work, both at the time and afterwards. One might say roughly that each new case represented at least some two hours' extra medical and clerical work every week.

The mention of clerical work brings me to the most wearisome, best hated, and, as usually practised, the most valueless and perfunctory of all the duties devolving upon Assistant Medical Officers in public asylums, viz. the writing up of the Case Books. This is a subject

upon which all Medical Officers speak most feelingly, and, from my own experience, most convincingly. The law upon the subject is strict, and most Superintendents, are very particular in seeing that in the letter at least it is carried out. Pasted on the inside cover of each Case Book are the rules and regulations which Parliament has enacted for the keeping of such books. These rules ordain that not only shall the personal description and medical diagnosis of each case be filled in at the time of admission, but that a *weekly* note at least, and oftener if necessary, shall be made on each patient for the first month; a subsequent *monthly* note on the same patient for the rest of the year, and a *three-monthly* note [1] in all chronic cases (Rule 13). Besides this, a *yearly* note is required on all cases which have been detained for a year or more. These yearly notes must not be confused with the *continuous orders* which have to be filled in at the end of the first year, and "thereafter for successive periods of five years," which are really continuations of the original Reception Order, and must be signed by the Commissioners; nor with the *special reports* which are necessary for the detention of ex-service patients. Besides these weekly, monthly, quarterly and yearly notes, "all special circumstances affecting the patients, including seclusion and mechanical restraint and all accidents and injuries," must be *at once* recorded in the Case Books. In addition, the Annual Register has to be posted up to date every three months, and there are the ordinary discharges, deaths, transfers, etc., to be entered in the books, besides innumerable forms, such as club certificates, death certificates, army forms, etc., to be filled up and signed, often as many as a dozen a

[1] Owing to the exigencies of war time, the Commissioners took it upon themselves to pretermit the three-monthly note. Nothing serious that I know of happened in consequence, and it is to be hoped that this relaxation of the rules will be continued, and the rules themselves thoroughly revised.

day; and on the occasion of the Commissioners' annual visit all behindhand clerical work has to be brought up to date and the books thoroughly overhauled. The clerical labour involved is pretty considerable, and takes up a great deal of the Medical Officer's spare time. It adds, when conscientiously and thoroughly done, another two hours at least to the daily duties, and this usually falls in the evenings when a little relaxation might naturally be looked for. But in ninety-nine cases out of a hundred the work is not conscientiously and thoroughly done, and human nature and asylum conditions being what they are, it is highly improbable that it ever will be. For in the case of at least half the work which the law requires him to do, the Medical Officer knows perfectly well that, if not unnecessary, it is really not medical work at all, and that any failure on his part to perform it properly will never be noticed. For most of these notes in the Case Books, to which I am now chiefly referring, however thoroughly and conscientiously done, are seldom or never read, least of all by the Medical Superintendent, and rarely, if ever, by the Commissioners. And assuredly no one else reads them. That I am not alone in this opinion the following quotation from Dr. Mercier's book on *Asylum Management*, to which I have so often been indebted, will prove. He writes:—

> As a rule, Case Books in asylums are very perfunctorily kept, though to this rule there are shining exceptions. The Medical Superintendent rarely interests himself in the Case Books. In some small asylums he writes the headings and makes the first notes on the patients on admission, but in most asylums the Superintendent seldom or never reads the Case Books (p. 210).

Dr. Mercier adds the significant statement, "The more the Medical Superintendent interests himself in medical work the more thorough the treatment of the patients will be," a view with which I am in hearty agreement, and which it is one of the main objects of this book to enforce.

It is, of course, obvious that Case Books must exist in all asylums, and that these books must be properly and accurately kept. There must be a record of all admissions, deaths, discharges, transfers, etc., and a description of each case, with all the salient facts connected with the history of the disease and its treatment, as well as details of all injuries, punishments, etc. This is obviously part of a Medical Officer's duties, and cannot be relegated to anyone else. And were the keeping of the Case Books confined to these matters, and were facilities in existence for keeping them accurately and making the notes taken represent the actual condition of the patients at the time, no fault need be found with the system. But there are usually no facilities for the Medical Officers making personal, private, and leisurely acquaintance with their patients. There are, as a rule, far too many patients allotted to each Medical Officer for the work to be properly done. And there is far too much clerical work put upon the Medical Staff which could be equally well done by the clerks in the Secretary's office. Medical men are not clerks, they are not engaged or paid as clerks, and should not be expected to do the work of clerks. Their purely medical duties, if properly performed, take up enough time as it is, and are far more important to the welfare of the patients than any clerical work, except such as is absolutely necessary.

Let me now suggest some reforms which I think will be endorsed by most Assistant Medical Officers who may do me the honour to read this book.

An interviewing or consulting room should be set apart for the Medical Officers in a convenient part of the asylum. Every morning from ten till eleven each Medical Officer should personally and privately interview a selected number of cases, say ten or a dozen each day. These cases should be previously collected by the Head Attendant on duty, who would be in attendance *outside the room,* and should consist of the new admissions, the

weekly and monthly note cases, with a proportion of chronics. In this way, by interviewing ten cases a day, a Medical Officer could in a month (and not including Sundays) interview two hundred and fifty cases, which is quite a sufficient number to be under any one doctor's charge. A "rough and ready" Case Book should be kept in the room, and an entry made against each patient's name at or immediately after the interview. In this way the notes would be the result of personal and daily knowledge, and not mere drafts upon the Medical Officer's memory, fortified by reference to the Head Attendant's opinion, as they at present often are. These notes should be afterwards copied into the Case Books by the clerks. The notes would thus be freshly made day-by-day records of each patient's mental state, and the Medical Officers would not only be saved an immense amount of unnecessary work, but would make intimate personal acquaintance in a short time with all the patients under their charge. They would learn more in five minutes' private conversation with each patient than they would gain from a dozen casual interviews in the wards or airing-courts. And the privacy of the interview, upon which I lay great stress, would give the patients confidence that their cases were being impartially investigated, unbiased by the presence and comments of the Head Attendants. I know that in my own case I should not only have been saved a lot of extra work and worry, but I should have had a far more practical grip and knowledge of my cases, and have gained a much broader grasp of the various types of insanity in a much shorter space of time, had some such system been in vogue. It seems to me that the two greatest desiderata in asylum practice are to establish as intimate and friendly relations as possible between the patients and the Medical Officers, and at the same time to provide opportunities for the latter of becoming interested in their work. Restore the confidence of the patients in the doctors by abolishing the attendant as a go-between,

and interest the latter in their medical work by relieving them of arduous and unnecessary duties, and you will have done more to improve the conditions of asylum life for both doctors and patients than in any other way. From an overworked, underpaid, and discontented Medical Staff no good work can be expected.

So much for the keeping of the Case Books, that bugbear of an asylum Medical Officer's existence. But it is not only the clerical work of the Case Books that the Medical Officer should be relieved of; such matters as the posting up of the Register, filling up and indexing the Registers of Deaths and Discharges, and transferring patients to their proper registers, etc., are all purely clerical duties and could be equally well performed by the office clerks. There is no doubt that numbers of promising Medical Officers have given up asylum work for which they were otherwise well fitted, and which might have had outstanding scientific results, in sheer weariness and disgust of the amount of clerical work imposed upon them. I have talked with many Medical Officers on this subject, and the unanimity of their views is remarkable, and often forcibly expressed. Dr. Weatherly, in his recent work, *A Plea for the Insane*, is equally emphatic on the point. Among his suggestions for reform is the following:—

> That the Superintendent and his Assistant Staff should have far less administrative and clerical work to do in order that more time might be devoted to that most necessary care and clinical knowledge of the patients (p. 219).

It is not only in Government departments that the worship of red-tape, and the filling in of countless forms, exists in all its vigour and rigour, of which we have had only too much evidence in the Great War and after. The filling in of forms and the flow of official ink is the very life-blood of all bureaucratic systems, and of all public institutions under their control. But clerical work,

however indispensable, is the work of clerks, and should be relegated to clerks wherever possible.

There are many other matters connected with the status and duties of asylum Medical Officers in which reforms are urgently needed, but these will be best left to the special chapter dealing with reforms. Enough, however, has been said in the present instance to make the reader aware that asylum Medical Officers in this country are a very ill-paid, overworked, and none too generously treated body of public servants, who yet are of great service to the State.[1] I have only occupied their position for the space of two years, but in that time I have learnt to understand and sympathize with their troubles, and to appreciate all the more on that account the general excellence of their work. If anything I have said in this chapter succeeds in drawing public attention to their case, and helps to rectify the difficulties of their position, it will not have been written in vain.

[1] There has been a great improvement in respect of the salaries of Assistant Medical Officers since the war, but their status remains much the same.

CHAPTER IX

ATTENDANTS, NURSES AND OTHER OFFICIALS

Having considered the duties and responsibilities of the Medical Superintendent and the Assistant Medical Officers of a public lunatic asylum, I must discuss now the equally, if not more important, question of the attendants and nurses. As I had much more to do with the male than the female attendants in both the asylums in which I served, the criticism I am about to make must be taken as applying chiefly to the former; but the reader will understand that the duties and responsibilities of the attendants were similar on both sides of these institutions, and that any remarks on the general question of asylum attendants will apply as much to the one as to the other.

There is no class of asylum officials whose duties are more important, or whose conduct has a greater influence upon the comfort and happiness of the pauper insane, than the attendants and nurses. In Dr. Mercier's words,

The attendants are the backbone of a lunatic asylum. The happiness and welfare of the patients while they are in the asylum depend far more on the character and conduct of the attendants than on those of all the rest of the asylum put together. To the comfort of ninety-nine out of a hundred patients in the asylum the removal and replacement of the Medical Superintendent is a matter of no moment at all in comparison with the removal or replacement of the attendant who has immediate charge of them. Upon the efficiency of the attendants depends hourly and momentarily the safety of the patients; upon the humanity and conscientiousness of the attendants depend hourly and momentarily the comfort, the happiness and the well-being of the patients. Without efficient

attendants, the best Superintendent that ever breathed is powerless to effect any improvement in his patients. With efficient attendants an incompetent Superintendent may find it an easy task to conduct an asylum without discredit. (*Lunatic Asylums*, p. 284.)

While not agreeing with this statement in its entirety, it is obviously to be inferred from it not only that the attendants are one of the most important factors of asylum efficiency, but that to secure that efficiency, they should be well trained and well governed, as well as well paid and well cared for. One might almost say that the best way to improve the condition of the patients in an asylum is to improve the condition of the attendants in charge of them. Contented attendants mean, as a rule, contented and well-disposed patients. But to be contented, attendants must be well governed, and this is where I disagree with Dr. Mercier's concluding statement. He seems to think that an incompetent Superintendent may be served by efficient attendants, and that under such conditions an asylum may still be "conducted without discredit." In my opinion, this is not possible, or is in the highest degree unlikely. It is my belief that an incompetent master is never efficiently served, not at least in public institutions, least of all in such public institutions as lunatic asylums. Incompetence in high office, especially when associated with almost autocratic authority, has a fatal habit of filtering down through all the ranks of subordinate officialdom. For incompetence under such conditions is too often combined with neglect of duty, vanity, laziness, etc., while injustice, meanness, tyranny are never very far off. And in such an institution as an asylum, each or any of these defects of character in a Superintendent are potent for evil all around. Especially have they this effect upon the attendants, so that it would be truer to say that upon the efficiency of the Superintendent depends the efficiency of the attendants, and through them of the whole asylum. Of their effect upon the Junior Medical Staff I have

already spoken, but upon the attendants the effect is of even greater consequence. For, as Dr. Mercier well says, the attendants are the backbone of the asylum, and upon them more than anyone else depends the comfort, happiness, and well-being of the patients.

But attendants must not only be well governed, they must be well trained. And here, I fear, the conditions of asylum service, in England at any rate, leave much to be desired. In Scotch asylums, from all accounts, things are very much better. It is true that under the auspices of the Medico-Psychological Association, to whose excellent work too much praise cannot be given, attendants have now to pass an examination before being certificated, as well as to attend preliminary courses of lectures combined with practical demonstrations, whereby the status and efficiency of asylum attendants have been considerably raised. And were attendance upon these lectures and the passing of this examination compulsory upon all asylum attendants and in all asylums, nothing but good would result. But this, as I understand, is at present far from being the case. Not only are the lectures and examinations not compulsory, but it is a fact that many Superintendents and asylum authorities object to their attendants being certificated, as it lessens their hold upon their services and their own authority, there being a greater demand for certificated attendants, who are thus inclined to transfer their allegiance elsewhere. It is the same with the National Asylum Workers' Union, which is affiliated with the Poor Law Workers' Union, and to which most asylum attendants belong. Many asylum Committees will not recognize this Union, and not a few Superintendents object to their attendants belonging to it, and for the same reason. It lessens their authority, and makes the attendants, in the opinion of the asylum authorities, too independent. But such short-sighted and antiquated opposition to the progressive tendencies of the age is doomed to failure, as it thoroughly

deserves to be. In this matter the attendants have my whole-hearted sympathy.

To return, however, to the question of training, and the value of examinations and certificates as means to that end. Necessary as I believe such examinations to be, and in my opinion certification and registration should be compulsory upon all attendants, male and female, it is not upon examinations alone that the efficiency of asylum service depends. Examinations may be a test of knowledge, though an inadequate test at best, but they are not a test of character, and it is upon an attendant's character and disposition, even more than upon his knowledge, that his true efficiency as an attendant upon the insane depends. And these qualities, while more or less innate, are largely affected by the character and conduct of those set in authority over the attendants, especially the Medical Superintendent and in a lesser degree the Assistant Medical Staff. An asylum attendant is apt to set his standard of conduct by that of his superior officers, and if he sees these neglecting their duty and regarding the patients' interests with indifference, he is prone to follow their example. A bad example at the top infects all ranks and quickly spreads. That is why I regard the training of the attendants not so much as a matter of book-knowledge and the passing of examinations, as one of example as well as precept set by their superiors. In my view a zealous, conscientious, and efficient Superintendent makes zealous, conscientious and efficient attendants and vice versa, and no asylum can be "conducted with credit" without both, although it may be quite possible for it to be favourably reported on by the Commissioners in the absence of either.

As I have throughout this book commented adversely upon so many features of asylum administration, I should like to put it upon record that in my experience the character and behaviour of the male attendants with whom I had to do, for I had little experience of the

female attendants, especially of the Head Attendants and Ward Charges, left on the whole a distinctly favourable impression upon my mind. They had their faults, of course, and I have not hesitated to mention such of these as, in my opinion, militated against their efficiency. But these seemed to me to be much more due to the defects of the system which they had to administer and under which they were trained, and to the monotony and dreariness of their life, with its many repulsive sights and sounds, than to any deficiency of kindness and good-nature. Callous and indifferent a few of them were, while want of tact and sympathy were not infrequently met with, but I met none who were deliberately cruel or inhumane. One must speak, of course, with a certain amount of reserve in these matters, for no attendant would show actual animosity or unkindness before a Medical Officer, and it is the rarest occurrence for any patient to complain of an attendant, for most patients regard the attendants as their virtual masters, as indeed they are, and are too wise to risk their displeasure. So that it is quite possible for petty acts of tyranny and injustice to be shown by attendants and for Medical Officers to be none the wiser, and this no doubt frequently happens. The qualities chiefly lacking in attendants are patience, tact, sympathy, and an understanding of the insane mind, the very qualities in which our whole system of asylum administration is itself deficient. Attendants, of course, must obey rules without questioning ; it is not for them to criticize or interpret them according to their own fancies. But though all attendants must act by rule, where rules have been laid down, the trouble is that, in other cases, where a certain amount of latitude and discretion is permissible, few of them think, or are encouraged to think, for themselves. For instance, it seems impossible for the ordinary asylum attendant of either sex, including even Head Attendants, to rid himself or herself of the prejudice that a lunatic asylum is

in reality a sort of prison, in which evil-disposed persons, who happen to be insane, are confined for their own and the public good. Hence arises in their minds the notion of the necessity for "punishing" them when they do wrong (a notion shared even by some Medical Officers who should know better), regardless of the obvious fact that such wrong-doing may be merely a result of their mental malady, or the direct effect of ignorant and unsympathetic administration. Thus, all offences and misdemeanours on the part of patients tend to be estimated by these officials according to their effect upon themselves. Probably, as has been stated, the two worst offences committed by patients are, from the attendants' point of view, "glass-breaking" and attempts to escape. They are so adjudged because they get the attendants into most trouble. In the same way, a patient's complaint against an attendant, however well justified it may be, is always regarded as a very serious offence by the latter. It is an attempt to get him into trouble with the Superintendent, and as such is deeply resented. And as attendants have many opportunities of showing this resentment, and making the complainants suffer for their temerity, such complaints are very seldom made. No overt act of cruelty or injustice is here referred to: such are always visited with proper severity by all Superintendents, and generally mean instant dismissal for an attendant found guilty of them; but there are many other ways, equally or more effective, by which an attendant can get even with a patient, without running any risk of dismissal. That this risk is ever before an attendant's eyes and governs his whole attitude towards the patients there is no doubt. He is even apt to think that he has fulfilled all reasonable requirements if he has done nothing to justify his dismissal. I have already alluded to the remark made to me by a Head Attendant on the occasion of an annual inspection. He thought the Report an excellent one because in it there was no reference to

any complaint made by a patient against an attendant. That the patients might have other causes of complaint independently of any actual injustice or cruelty on the part of the attendants never seemed to enter his head. Yet he was by no means an unintelligent man, and on the subject of the attendants' grievances could be outspoken enough. But he could not see that, just as the attendants had their own grounds for complaint, so the patients might have them too.

That there are such grounds, in the case of the attendants, I have already shown. These grounds are chiefly two: Their Union is not yet officially recognized by the authorities of all, especially English, asylums; and their hours of work and rate of pay are not in accordance with modern conditions.[1] The remedy for the first lies mainly in the hands of the Union aforesaid; that of the second, partly in the same hands, and partly in an alteration of the Lunacy Laws. The proper proportion of attendants to patients should no longer be left to the discretion or whim of asylum Visiting Committees, but should be clearly defined in the Act. This proportion should be determined by the Board of Control, acting as the advisory department of the Ministry of Health, and having once been fixed should not be departed from without due cause shown, such as the temporary illness of an attendant, absence on short leave, etc. Competent authorities estimate the minimum proportion of attendants to patients in public asylums as one to ten, and most Medical Officers would agree with this. In Dr. Mercier's words:

> With less than this number it is not possible that the patients can be properly attended to, that is to say, if they are of the usual mixed class, and not all chronic imbeciles and dements; nor is

[1] These remarks apply to pre-war conditions; there have been considerable improvements in both respects, I believe, since the war.

it fair, with a less proportion than this, to hold the attendants responsible for all that may occur in the wards. It must be remembered that the full staff of attendants is present in the wards only on exceptional occasions. Some are always absent on leave; some are out with walking or working parties; some are ill; some are watching special cases, and are not available for the ordinary duties of the wards. To estimate the number of attendants required, it is necessary, therefore, first to calculate the minimum that are needed in the wards, and then to add to these a sufficient number to compensate for those who must necessarily be absent from the causes above specified, and to provide for such contingencies as the watching of suicidal cases and the nursing of patients dangerously ill. (*Lunatic Asylums*, pp. 294, 295.)

There are many other causes for complaint as regards the treatment of attendants by the asylum authorities, but here I need only mention one more, because of its effect upon the comfort and welfare of the patients. I have said that contented attendants make contented patients, and vice versa. The treatment of the attendants differs greatly in different asylums, but still, as far as my experience goes, leaves much to be desired. How is it possible for attendants to be contented, and for the best work to be got out of them, if little or nothing is done to make them comfortable, or to provide them with opportunities for suitable recreation? The majority of attendants are young, unmarried men and women, and need relaxation and recreation like young people of every class, and all of them, of whatever age, require opportunities for rest and reading and indoor amusements, as a set-off against the constant strain on mind and body of looking after lunatics. A recreation and reading room, which should contain a piano (and in the cases of the male attendants a billiard-table), as well as a dining-room, both situated *apart from the wards*, and, if possible, in a separate wing of the asylum, should be provided for both sexes, as well as a tennis-court, where the younger attendants and asylum officials could obtain some well-needed exercise. I have already spoken of

the necessity for outdoor games, such as football and cricket, for both attendants and patients. As regards the food of the attendants, it should, like that supplied to the patients, be far more varied, and much more appetizingly cooked and served than was the case in my experience; in fact, most that has been stated as regards the patients' food applies with certain reservations to that provided for the attendants. But few Superintendents, and fewer Visiting Committees, seem to bother their heads about such a subject. Besides an attendants' food, there is the question of his uniform. In the asylum from which most of the facts in this book are taken, though all the attendants were in uniform, no uniform greatcoats were supplied, or were allowed to be worn. When I asked why, the answer was that the Superintendent did not think it "looked smart." This is an instance of want of thought akin to that which ordains that pauper lunatics shall wear a distinctive garb, and equally to be deprecated. Another privilege that would be highly appreciated by male attendants is that of extending the hours during which they are allowed to smoke. It is not desirable, of course, that they should be allowed to smoke while on duty in the wards, but it is an unnecessary restriction to prohibit smoking when on duty out of doors, or before 8 p.m. One Superintendent I knew used to allow his attendants to smoke after 5 p.m., and never found that any serious deterioration resulted.

I have spoken above of the necessity that attendants should be well trained, and a few more words on this subject may not be out of place. For this purpose attendants should be divided, like hospital nurses, into probationers and fully qualified or certificated attendants. The probationary period should last for at least one year, and during that time attendance on a course of asylum lectures, as instituted by the Medico-Psychological Association, should be compulsory. These lectures should be given by the Senior Medical Officers on the male and

female sides, and should consist of two courses of three months each, summer and winter, with practical demonstrations. Failure to pass the qualifying examination and to obtain the necessary certificate at the first attempt would not (*ipso facto*) involve dispensing with the candidate's services, but would necessitate his coming up for examination again in six or twelve months time. A second failure should disqualify from future service. All certificated or uncertificated attendants of either sex should be registered, and a list should be supplied to all asylum Visiting Committees, and no unregistered attendant of either sex should be allowed to be employed. I may add that as attendance upon these probationary lectures should be compulsory on all uncertificated attendants, they should be delivered during duty hours, and count in the record of the day's work. Another matter of importance may be noted in this connection. Whenever an attendant is dismissed by the Medical Superintendent for any cause, it is very desirable that the dismissal should be endorsed by the Visiting Committee, to whom the attendant should have the right to appeal. I am informed that this course is not invariably followed in many public asylums, and where this is the case it is obvious that no feeling of security can exist among the attendants, who have no guarantee that justice will be done them should they be so unfortunate as to offend that autocrat of the asylum, the Medical Superintendent. Discipline is necessary, but tyranny is odious.

There is one other matter to which reference must be made before we leave the subject of the attendants, for it is one of the greatest practical importance. This concerns the employment of female attendants in the male wards. I have already touched upon this question when alluding to the lack of female nurses in asylum hospital wards. But it is not only in the hospital wards that this lack is felt. I have long been of the opinion, shared by many alienists and not a few Medical Superintendents,

that it would contribute immensely to the health and happiness, as well as to the prospects of recovery, of male patients, were female attendants as well as male employed in the male wards of public asylums. The experiment was first tried, I believe, in the United Kingdom by the present Professor of Psychiatrics in Edinburgh University, Dr. George M. Robertson, when he was Medical Superintendent of Morningside Asylum, and with the greatest success. It has formed a feature of the administration of this asylum ever since, and has been followed in many other Scotch and a few English asylums with the happiest results. In a paper read some years ago before the Medico-Psychological Association, and published in the *Journal of Medical Science*, Dr. Robertson detailed his system and the experiences which led up to it and have followed from it, and answered the objections which were raised against it. It would take too long to detail the reasons which led to his making the experiment, and the advantages which he claimed from this innovation; suffice it to say that he found that the change was greatly appreciated by the patients, and that none of the evil results which were expected to follow from it actually occurred. Even the most refractory cases were found to be more amenable to female than male control. Nor is this altogether to be wondered at. Women, as a sex, are much more patient and conciliatory than men, especially with the opposite sex, and these are virtues of quite inestimable value in the treatment of mental cases. The presence of women attendants would have a humanizing effect throughout the entire male wards, and might lead to the abolition of many of the evils portrayed in this book. Of course there are many duties in male wards for which a female attendant is unfitted, which will occur to any intelligent reader, but this difficulty can be overcome by having a certain number of additional male attendants in every ward. Unfortunately, I hear that the Asylum Workers' Union has so far set its face

against this innovation, but it is to be hoped that its opposition will soon be removed.

How often have I not wished for a woman's co-operation when dealing with male cases, especially those "confusional" cases due to shell-shock in ex-soldiers, so many of whom are now drifting into our asylum wards. One such case I particularly remember. He was only a lad, not more than twenty, and had been transferred from a military hospital. His was clearly a case of what French physicians call "commotional" shell-shock. He was intensely confused, and had the greatest difficulty in making himself understood. This "commotional aphasia," as one might call it, was very distressing, not only to the onlookers, but obviously to the patient himself. He simply *could not* get the words out that he wanted to say. He was, besides, thoroughly frightened, and, in consequence, "resistive." He seemed to imagine that everybody about him was a German and an enemy. It was thus very difficult to do anything for him. He refused his food (probably he thought it was poisoned), he refused to dress, he refused to obey orders, and, when remonstrated with, "resisted." He did not in the least realize where he was, and probably took the place for a German prison. He used to gaze at us in the most pitiful and appealing way as if he wondered why we could not understand him. The Ward Charge was an experienced attendant, rough but kind-hearted, but, as he told me, he "hadn't time to be bothered with him." The consequence was that the poor lad was put "behind-the-table," and spent most of his time there and in the "cells," and when at exercise he was of course in the "pen." The attendants thought he was safer there, as they never knew what he might be up to—and he probably was. But it was certainly a grave reflection upon the asylum administration, and I constantly intervened on his behalf and restored him to comparative liberty. Solitary confinement in a dark cell was the last way to help him to

recovery, but such was the dearth of attendants during the war that there was often no alternative. His sisters, who were evidently devoted to him, came to visit him constantly, and all they told me made me redouble my efforts to help him. They said he had volunteered for service while under age; that he had served two years at the Front, and had been badly wounded. While in hospital in France he wrote most cheery letters home, and had made light of his wound for his mother's sake; she was ill at the time and had since died. He had recovered and come home on leave, and had then gone back at once to the Front, where he was almost immediately shell-shocked. Transferred to a military mental hospital at home, he had been "treated" for a few months (after reading the recent articles in *Truth*, one wonders what this "treatment" may have been like), but making no improvement, was certified as insane. The boy had been well educated and well brought up, and had intended to follow his father's profession, which, I believe, was that of a land surveyor. Had he been an officer, he would have been sent to one of the many luxurious mental homes instituted for the treatment of such cases. Being only a private, he had, like hundreds of others, been simply drafted into a pauper lunatic asylum, where he may become hopelessly insane. Such cases, in my opinion, ought never to be sent to an asylum at all. In a country as wealthy as England is, even after all her war losses, it is scandalous that those who have given their all in her defence should be so scurvily treated. We see all around us, on the one hand, millionaire profiteers; on the other, maimed men and shell-shocked and demented ex-soldiers. It is a heartrending spectacle, especially when one recalls the solemn undertaking of the War Office that no mentally afflicted soldiers should be treated as pauper lunatics, and no shell-shock cases sent to pauper asylums. In a case like the above a woman's help would have been invaluable. The boy wanted mothering, not

dragooning into obedience. With wise and gentle management he might have soon recovered; as it is, I fear to think what may have happened to him.

I have left myself little space in which to speak of the other asylum officials, their duties and responsibilities. I have already alluded to the work of the Housekeeper and the cook, and have shown how in my experience it fell far short of the required standard, and I shall say nothing further upon this head, and upon that of asylum cooking in general, important as this is from the standpoint of the patients' health and their chances of recovery. I need only add, as regards the Housekeeper, that her duties should be strictly delimited, and separated from those of the Matron, who is the counterpart of the male Head Attendant, on her side of the asylum. Unless great care is taken, the duties of these two officials are apt to clash, with resulting friction and unpleasantness to all concerned. In small asylums the two offices can be combined, but in large asylums, where they are necessarily separated (and few asylums of any size can be properly conducted without both), the Matron should be regarded as the supreme female authority under the Medical Staff, and should have entire charge of all matters connected with the female patients and the management of the wards. To the Housekeeper should be allotted the management and supervision of the kitchens, laundries, and work-rooms, and the charge of all the purely domestic servants. The female patients who work in the laundries, kitchens, and work-rooms would thus be under the charge of the Matron, while the ward-maids who work in the wards would be under the supervision of the Housekeeper. In actual working this division of authority should not lead to any trouble. With strict delimitation of their duties, it should be possible for the Matron and Housekeeper to work harmoniously together, and thus avoid an illustration of the truth of Dr. Mercier's sarcasm that "in asylums, where both Matron and Housekeeper are employed,

it frequently happens that the Matron has little to do except to walk through the wards and dress becomingly."

The position of House Steward requires more detailed notice, for this office ranks next in importance to that of the Superintendent himself, and in those asylums where the sphere of action of both is separated, and each is separately responsible to the Visiting Committee, the office of House Steward, though ranking below that of Medical Superintendent in official precedence, is for all purposes, other than those of discipline, of almost equal importance to that of the Medical Superintendent himself. Here, again, I cannot do better than quote what Dr. Mercier has to say on the subject. He writes :—

> The duties of the Steward vary very much according to the size of the asylum and to the share of the Steward's duties which is performed by the Medical Superintendent. In some asylums the whole of the proper duties of Steward are divided between the Medical Superintendent and the storekeeper, but this is not an arrangement which can be recommended. The Steward is the superintendent of the whole of the *materiel* of the asylum. He is responsible for the maintenance in good repair of the fabric and fittings of the building and the furniture, for the decorations, for the whole of the supplies of food, clothing, fuel and other stores, and for the efficiency of the drainage, ventilation, heating and lighting of the establishment. His office is, therefore, one of the highest importance and responsibility, and the man chosen to fill it should be one of wide experience and *proved integrity* (italics mine). In large asylums he is very commonly independent of the Superintendent, and reports directly to the Committee, and in such cases he needs to be a man of much tact and *savoir faire* to avoid friction and disputes as to jurisdiction. (*Lunatic Asylums*, p. 277.)

Holding such a position and with such duties, it is obvious that the post of House Steward in a large asylum is a very onerous one, and that he is an officer of nearly equal importance, though not of equal official rank, to the Medical Superintendent. He is, in fact, the executive superintendent of the asylum, and as regards the comfort and welfare of the patients only second in importance

to the Medical Superintendent himself. His post is one of equal personal responsibility, while financially, of course, it is the more important of the two, and for this reason should be well paid. I emphasize this fact, and the necessity for the "proved integrity," to use Dr. Mercier's words, of the holder of this post, for the reason that he has many opportunities and great temptations to abuse his position. Large sums of money pass daily through his hands, and the arrangement and supervision of the very large contracts for the asylum stores necessarily give opportunities for a dishonest Steward to subordinate the interests of his employers to his own private advantage. I am far from suggesting that the opportunities placed in the hands of the Chief Steward of our public asylums are often abused. I merely point out that they are such that no loophole for dishonesty should be overlooked. The law is very strict in forbidding any member of the Visiting Committee to be "interested either in his own name, or in the name of any other person, in any contract entered into, or work done, for the Committee." (Lunacy Act, 1890, Sect. 174.) But the Steward is not a member of the Committee, and no provision is made by the Lunacy Act to render impossible, or even difficult, the abuse of his opportunities. Of course, in receiving commissions on contracts he would be breaking the common law and running considerable risks. But for a clever and unprincipled man there are other means of abusing his opportunities apart from the taking of commissions. It is true that all contracts made by the asylum authorities, i.e. by the Visiting Committee, who are legally responsible, are ordered to be entered by the clerk in a book kept for the purpose, and deposited with the local authority, which book is to be "open for the inspection at all reasonable times of any person contributing to the rates" (Sect. 256), but it is difficult to see how under this provision any means exist of detecting whether the *quality* and *quantity* of the goods supplied is the same as that con-

tracted for, or whether all stores supplied are put to the use for which they were intended. In fact, it would appear that many opportunities exist of defrauding the patients and the public in these important particulars without anybody being the wiser, especially in those cases where the Superintendent is in supreme control, and where the House Steward, or Chief Clerk as he is usually called, can always shift the responsibility for these transactions upon the Superintendent, should they be questioned, which, considering the multifarious nature of the Superintendent's duties, and his usual ignorance of commercial matters, is not likely to be the case. Is it suggested, for instance, that the Superintendent is always present when the goods in question are tested and weighed? The Commissioners themselves seem to have been conscious that extra precautions against fraud and dishonesty were needed in these transactions, and in their Report for 1909 have drawn up an elaborate code of rules for the stocktaking of the stores and the auditing of County and Borough Asylum accounts, rules which are evidently intended to meet the special points above alluded to. It will be observed, however, that these are only "model rules" or counsels of perfection, compliance with which is left to the discretion of Visiting Committees, and there appear to be no penalties attached to the non-observance of them. But it is not much use the stocktaker "comparing the entries and bills with the counterfoils of the orders and contract prices" (*Fry on Lunacy*, p. 649), if there is no means of accurately checking the quantity in hand when fresh supplies are ordered, and of following up and controlling its disposal, which duties, in fact as well as in name, should devolve upon the agent really responsible, in this case the Superintendent. Moreover, when goods, such as tea, rice, sugar, etc., are ordered by the hundredweight at a time, it is quite possible for discrepancies to exist in their reception and distribution, and yet not to appear upon the books. And such dis-

crepancies would, as I say, be less easy to detect in cases where, though the Steward or Clerk was the actual agent in the matter, the Superintendent was nominally the responsible party. For all these reasons it is obvious that the Chief Steward of an asylum has great financial responsibility, and should be a man of "proved integrity," and that any arrangement whereby this responsibility is nominally in the hands of one man, but actually in those of another, is to be condemned, as not conducing to the public advantage, and to the objects which the law sets out to provide.

The rules, moreover, for stocktaking and auditing the accounts of County and Borough Asylums leave something to be desired. The accounts of County Asylums have now to be audited according to the provisions of the Local Government Act (Lunacy Act, 1891, Sect. 18), whereas Borough Asylums are not subject to any audit by the auditors of the Local Government Board, and are merely *recommended* by the Commissioners to appoint an independent auditor. In the same way, the appointment of an independent stocktaker for County and Borough Asylums, though approved and recommended by the Commissioners, is apparently left to the discretion of the Visiting Committees. A better plan would be to make the appointment of independent stocktakers and auditors compulsory in both cases. It is imperative in the public interest, not only that asylum accounts should be accurately kept and independently audited, but that every means should be taken of securing that the management of all asylum contracts should be absolutely above suspicion.

Only one other asylum official need be referred to in this chapter, and that is the Chaplain. "Though the relations of the Chaplain to the other officers of the asylum are not very close," says a wise and able critic, "it is of great importance that he should be, as he ought to be, a peace-maker, and not a tale-bearer, nor a tattler, nor

a mischief maker." But though the Chaplain's relations with the other officers are not close, they should be as close as he can make them with the patients. It is a difficult post to fill, and requires above all things tact, cheerfulness, and sympathy. There is no need for the Chaplain to be an eloquent preacher, nor a man of pronounced theological views, nor strongly inbued with the spirit of sacerdotalism. He should be above all things a man with liberal views and varied attainments, among which musical ability is of great service. He is expected to take a prominent share in amusing and entertaining the patients, and superintending their games, though in my experience this was seldom or never done. If he can play cricket and tennis, or even football, so much the better. It will stand him in more stead than being able to preach a good sermon. Not that many insane persons are necessarily incapable of appreciating a good sermon—far from it. I have known some with a faculty for theological disputation which might puzzle even a bishop. But the majority of the insane are not benefited by long sermons, and are not capable of giving sustained attention to any subject. But they appreciate very much a bright, and even ornate, service, in which the singing of hymns is a prominent feature. Many of them sing very well, and a certain number are very fair instrumental performers; and for this reason a Chaplain who is musical himself, and can teach and lead a choir, the elements for the formation of which exist in most large asylums, is highly thought of. But, above all things, it is necessary for the Chaplain to take his professional duties seriously, and to be sufficiently interested in his patients to do all that lies in his power to alleviate their lot. He has endless opportunities for personal help and consolation, as well as social service, but no man should take the post of asylum Chaplain who is not prepared for much uninteresting and at times distasteful work. Upon the Chaplain falls, besides, the office of librarian,

and it is a recognized part of his duty to see that the books of the asylum library circulate in the wards. Many Chaplains to lunatic asylums take their duties anything but seriously, and frequent the wards as little as possible. Those who so act have mistaken their vocation. But the post, as I say, is a difficult one, and needs special qualities of mind and character.

CHAPTER X

GENERAL ADMINISTRATION OF PUBLIC ASYLUMS

I APPROACH now the subject of the general administration of public asylums, which is one of great importance, and in which the necessity for reform is, in my opinion, urgent. We have seen that the great blot upon the present system, at least in this country, is that there are no organized methods of remedial treatment, that public asylums for the most part exist merely to confine, not to cure, the insane. If the patients improve during their confinement, so much the better; if they do not, so much the worse—for them. In neither case do the Medical Staff or the attendants concern themselves greatly with the result. It is for Providence, or the patients themselves, to bring about a cure; it is no immediate concern of those in charge of them. I will not say that there may not be honourable exceptions to such an attitude. Here and there a conscientious and self-sacrificing Medical Officer, on his first appointment, may take sufficient interest in his cases to attempt to investigate, and, if possible, to hasten Nature's efforts at a cure, but these exceptions are few and far between, and the self-engendered zeal soon dies a natural death, asphyxiated in the general atmosphere of apathy and neglect that broods over most lunatic asylums, and sooner or later affects all those that dwell within them. It is my belief that these generous impulses, which undoubtedly exist in many cases, are ruthlessly strangled by red-tape. There

is such a luxuriant and impenetrable undergrowth of officialism, such a mass of forms to fill in and of clerical work to be done, that the medical neophyte tends to give up his early enthusiasm in sheer ennui and disgust. The ruts of official routine have been worn so deep that he no longer struggles to get out of them, but sinks into the condition of apathy and indifference that he sees everywhere around him. Though for this result (and I gladly admit that there are many honourable exceptions to it) our system of asylum administration is no doubt largely to blame, there are possibly other and deeper causes. No one who has not experienced it can have any conception of the melancholy and depression, especially for a sensitive and sympathetic nature, that pervades the whole atmosphere of a large lunatic asylum. Not only is the spectator oppressed by the vision of the human wreckage which he sees everywhere around him, the melancholy *detritus* of minds once as normal and active as his own, but he is oppressed still further by the vague sense of poisonous spiritual exhalations which seem to permeate the asylum precincts, and may have, for all he knows, some mysterious share in the malady from which the victims of insanity are suffering. It needs a stout heart and steady nerves, as well as keen but disciplined sympathies, to endure for years at a time without moral and intellectual deterioration the sights and sounds of asylum life. No wonder that many asylum doctors become disheartened and finally apathetic, that others take to drink or drugs, and that a few commit suicide. All the more honour to those who manfully stick it out, who take a scientific interest in their work, and do all in their power to alleviate the lot of those of whom they are in charge. There are many such, Medical Superintendents and Medical Officers alike, working in British asylums to-day, and nothing I have said in this book should make the reader overlook the fact. That there are not more it is my profound con-

viction that our system of asylum administration is chiefly to blame. And since it is with the faults of this system that this book mostly deals, no attempt at reform can expect to bear fruit which does not emphasize the evils and abuses of which it hopes to get rid. But that there is a brighter side to the picture the reader, I trust, will now be aware. It is to increase that side and make it predominate that this book has been written.

Equally important, and equally in need of reform, are the constitution, powers, and sphere of action of the Visiting Committees. The law holds them, and rightly holds them, responsible for the entire administration, medical and executive, of the asylum, under the Board of Control. Most of their medical responsibility is, as we have seen, delegated to the Medical Superintendent, and it is difficult to see how this can be avoided. Nor would it have any ill-effects, provided only that the Superintendent regarded his medical duties as his chief concern. The Board of Control is, or should be, quite capable of seeing that these are properly carried out. It is otherwise with the executive functions, and here the House Steward should be responsible to the Visiting Committee alone. But there are other powers, at present vested in the Visiting Committee, which, it seems to me, should be retained by the State, as impersonated by the newly formed Ministry of Public Health. I have already alluded to some of these powers in the preceding chapters of this book, and need only briefly refer to them again here. They concern such matters as the size of asylums, and the number of patients contained in them; the construction of new asylums, and the additions to and alterations of existing ones; the sanitation of these buildings; and the proportion of Medical Officers and attendants to the number of the patients. None of these matters, in my opinion, should be left to the discretion of the Visiting Committees of public asylums,

but should be regulated by the State, acting on the advice of the Board of Control, if this body still retains its present constitution and sphere of action, and if not, by the consultative Medical Council or Advisory Board of the Ministry of Public Health. When once these matters have been fixed by the central authority, i.e. by Parliament, and embodied in legislation, it will be for the Visiting Committees to carry them out, and for the local authorities, or County Councils, to levy the necessary rates for that purpose. But the whole matter of Poor Law administration, which will henceforth, it appears, be taken over by the Ministry of Public Health, is far too complex and difficult a subject to be discussed in a book of this sort. I can only throw out tentative suggestions for such reforms as bear upon the condition of pauper lunatics, leaving their examination and adjudication to the experience of those who are far more competent for the task than I am.

There is, however, one more matter connected with the functions of Visiting Committees to which I must now refer. It is laid down in the Lunacy Act of 1890 (Sect. 188) that—

> At least two members of the Visiting Committee shall together, once at least in every two months, inspect every part of the asylum, and see every patient therein, so as to give everyone, as far as possible, full opportunity of complaint, and examine the order and certificate or certificates for the admission of every lunatic admitted since the last visitation, and the general books kept in the asylum; and shall enter in the visitors' book any remarks they think proper in regard to the condition and management of the asylum and the lunatics therein, and shall sign the book upon every visit.

This appears to me an admirable provision, and was evidently designed with the object of keeping the Committee thoroughly acquainted with the condition and conduct of the asylum, and with the state of the patients contained within it, as well as offering the

latter a sense of security, and the feeling that their interests were a matter of concern to the asylum authorities. Visiting, then, is clearly one of the duties demanded of the Committee, and indeed is one of the *raisons d'être* of their existence. Yet, so far as I was able to judge, this duty appeared to be treated practically as a dead letter. It was a commonplace among the temporary Medical Officers in my time that, whatever else the Visiting Committee might do, they certainly never "visited," i.e. on any systematic or thorough-going scale. Occasional visits to the wards, workshops, farm, etc., there may have been on Board meeting days, but of systematic visiting of patients in the asylums with which I was connected there was none. Very few visitors turned up at the Board meetings before the dinner hour at one o'clock, except those who were deputed to visit the farm and outbuildings; and all of them had usually gone away by 3 p.m. As the dinner lasted well over an hour, and the rest of the time was taken up in listening to the monthly statement of the Superintendent and the clerk, there was obviously not much time to spare for carrying out this particular provision of the Act. I myself, during two years' official residence, never once saw a visitor in the male wards, and I never even heard of one interviewing any patients, though they may, of course, have spoken to such as they met in casual visits to the wards and about the grounds. But there was nothing resembling or approaching the "inspection of every part of the asylum, and the visiting of every patient contained therein." Not that it mattered much. Visiting of the kind prescribed in this part of the Act could only be of a purely perfunctory nature, and the framers of the Act must have had a very imperfect acquaintance with, or else a very high opinion of, official human nature, if they imagined that their injunction to the visitors to "visit every patient in the asylum every two months" ever would be, or indeed could be, carried

out. Can one imagine some three thousand patients of both sexes being personally visited, and individually interrogated, by two members of the Committee every two months? The thing is absurd on the face of it. And yet the *intention* of the Act is admirable, and the object in view of the very first importance, viz. that the visitors should be acquainted at first hand with the treatment the patients were receiving, and that the patients should have an opportunity of making complaints to the governing body. As things are at present, they can only make complaints to the Medical Officers or the Superintendent, and as these complaints would naturally in most cases be a reflection on the medical conduct of the asylum, and ultimately of the Superintendent, it is hardly likely that they would be impartially considered, if they were considered at all. The effect of this is just what this provision of the Act was intended to prevent, viz. that the patients are for all practical purposes shut out from the outside world, and have no means of stating the wrongs from which they feel they suffer, or of getting them redressed. But a practical interpretation of the intention of the Act could be easily arranged whereby both these objects could be realized. Were a committee-room set apart for interviews on Board meeting days, and were it known that two of the visitors would be in attendance during specified hours, say from ten to twelve, on these days, when patients who had any complaints to make could be interviewed *in private*, much good might result. To guard against any accidents or any frivolous or vexatious abuse of such a privilege, the names of all patients wishing to interview the Committee should be passed by the Medical Officers in charge of them. The presence of a Head Attendant would not be necessary at these interviews, and indeed would frustrate their main purpose, but one could always be on duty outside the room, and his presence requisitioned, if necessary. In

this way the patients would feel that their interests were not neglected, that they had, so to speak, friends at court, who would have the power to rectify abuses, should such be disclosed. This would tend to re-establish a confidence which, as things are now, is sadly lacking, and which is the cause of many heart-burnings and profound dissatisfaction on the part of the asylum inmates. Such an arrangement is really all that is necessary to carry out this provision of the Act, especially if the injunction to the visitors to "visit every part of the asylum" were rigidly complied with as well. In both these respects the Visiting Committee would justify their existence, and would really become acquainted with the asylum and the patients under their charge.

And, indirectly, the public would become acquainted with asylum administration as well, which would be greatly to their advantage. Far too much secrecy exists at the present time as to what goes on in these institutions. Even medical men have the greatest difficulty in acquainting themselves with the conditions of the patients in our public asylums. A case recently reported by Dr. Weatherly in the medical papers is very instructive in this respect. He had been asked by the friends of a patient to visit the latter in the asylum in his capacity of mental specialist, and to report on his condition. The interview duly took place, but when Dr. Weatherly asked for permission to see the notes of the case in the Case Book, this was peremptorily refused. He then asked to see the Medical Officer in charge of the case, but was told that he was engaged. Finally, he put a few questions to the Head Attendant, who was told off to accompany him, only to hear that the latter had instructions from the Superintendent to answer no questions about the case. In fact, every obstacle that could be put in his way to prevent his obtaining the information he was in quest of was employed, and he was obliged to leave the asylum little wiser than when he came. Dr.

Weatherly was so indignant at the treatment he received that he took legal proceedings against the asylum authorities. When the case came into Court the presiding Judge upheld the Superintendent's action, on the ground that the Case Books were the property of the asylum. Such a state of things is little short of scandalous. With justice may the public suspect that all is not as it should be in our pauper asylums, when such determined attempts to maintain secrecy are not only openly practised, but are even upheld by the law. What possible harm could there be, or infringement of personal rights, in allowing a well-known and independent alienist to see the notes of a patient whose case the patient's friends had asked him to investigate, and whom he was legally entitled to visit? The law certainly requires altering if, while empowering the performance of a public duty, it renders its effective discharge nugatory. The above case is only another instance of the despotic power conferred upon the Medical Superintendent of a public asylum.

Before leaving the subject of the Visiting Committee there is another matter on which I might add a few words. It would be, in my opinion, a great advantage if two of the members, at least, of this Committee were women. I am aware that women are entitled to sit, and in some cases do sit, on these Committees, but in my opinion it should be made compulsory for every Visiting Committee to elect two women members to its body. Women, as a rule, are much more conscientious, as well as much more inquisitive than men, and have not the habit of taking things for granted quite so readily as our sex. The presence of one or two women upon these Boards would have the effect of keeping them up to the mark, and making them more alive to their public duties. Their presence, indeed, seems naturally called for in view of the fact that most pauper asylums contain more women than men. There are many matters, especially those connected with the food and the comforts

of the patients, that women would be more alive to than men. A Committeewoman who made a point on each Board meeting day of inspecting the kitchens, laundry, work-rooms, etc., would be able to detect many of the defects of administration to which I have alluded in these pages, and to inaugurate many improvements.

Here I may refer to a matter already glanced at in a previous chapter, viz. the great waste of the psychological material for the study of insanity provided by our asylums. I have already referred to this subject in connection with the duties of Medical Officers of asylums, but the same criticism is applicable to the utilization of this material by the medical profession as a whole. It is a commonplace in the profession how ignorant general medical practitioners are as a body of the problems of insanity, an ignorance of which I was very conscious myself before I had any asylum experience. The ordinary course of lectures on psychological and forensic medicine, which medical students have to attend before going up for their final examinations, is quite useless as a guide to the practical knowledge of insane problems. But if every student had to supplement this course by attendance during his final year at classes *held in an asylum*, where practical demonstrations could be given by the lecturer on the various types of insanity, a serious hiatus in the present medical curriculum would be adequately filled. As all British Universities granting medical degrees and diplomas are situated in large towns within easy reach of a County Asylum, no great difficulty would be encountered in providing for such classes. It is just as imperative for the young doctor commencing practice to have a working knowledge of mental disease as of physical disease. Both will meet him in his professional career, and as much harm to his reputation and to the interests of the public may result from his inability to differentiate between subacute mania and delusional insanity, or to diagnose a case of early general

paralysis, as from his failure to recognize a strangulated hernia or a case of Bright's disease. In fact, it is possible that more public harm will result from his ignorance in the former case than in the latter. It should be permissible, too, for any qualified man in the neighbourhood to attend these classes on payment of a small fee ; in fact, post-graduate classes in psychological medicine might in this way be combined with graduate classes. This would be a boon much appreciated by the general medical practitioner, and would lead to the more accurate filling-in of medical certificates in cases of insanity, and the more general recognition of incipient mental disease, i.e. of insanity in the stage in which it is most curable, than obtains at present. To meet this difficulty in the latter case, it has been suggested in recent discussions upon this subject that wards should be opened in all the large general hospitals for the admission of early mental cases without certification, and for out-patient cliniques in which such cases might be studied by students and medical men in practice. This would be a great improvement upon the existing state of the law, but there are many objections to it which I shall consider more fully in the chapter dealing with reforms. For the present I need only say that, in my opinion, it would not adequately supply the need referred to. It is not only *early* mental cases that a practising physician needs to recognize, though these are doubtless the most important. He needs to recognize the various types of acute and chronic cases also, and these he would only be able to see in the wards of a public asylum. In a word, when once we treat our public asylums as the mental hospitals they should be, we shall be able to make use of the material they contain for the advancement of medical knowledge in general, in the same way that our ordinary hospitals are made use of for the teaching of physical disease.

The mention of hospitals will fitly introduce a subject

of great importance in asylum administration, which, as far as most public asylums are concerned, has been almost entirely neglected. I refer to the practically complete absence of any adequate provision for hospital treatment in these institutions. Here there exists an almost illimitable field for improvement. It is generally assumed by the outside public that the inmates of lunatic asylums are only mentally afflicted ; it is seldom realized that a large number of them are often physically sick, and that many, indeed, are permanently bed-ridden. Yet, where in this country is the public lunatic asylum that has a properly equipped hospital ? I have alluded to the general absence of an operating theatre ; but in few public asylums is there even an operating table, or a proper assortment of surgical instruments. In both the asylums in which I served the instruments were old, dirty and neglected. There was no operating theatre and no operating table, and on neither the male nor the female sides were there trained surgical or medical nurses. The only nurses on the male side were male attendants, and none of them had had a hospital training. There was a great dearth of hospital dressings, surgical bandages, etc., and no means of sterilizing instruments or towels. Why there should be these grave defects it is impossible to understand, except on the supposition that operations upon lunatics should not be encouraged, and so are not provided for ; it is thought to be cheaper to let the patients die. And die many of the surgical cases did, purely for want of facilities for operations, and owing to the lack of trained nurses and competent surgeons. For even were proper facilities for operating provided, these latter deficiencies would constitute a fatal obstacle to efficient and successful surgery. Few Medical Officers or Medical Superintendents have the necessary surgical experience for the performance of major operations, and at no English County or Borough Asylum that I have heard of is it the custom to appoint a visiting surgeon

from outside, though the Lunacy Act (1890, Sect. 276) gives power to Visiting Committees to make this appointment. It has come to my knowledge that, since leaving my last post, the Visiting Committee have appointed a foreign locum tenens who served during the war as surgeon and pathologist to the asylum. Apart from the undesirability, to say the least of it, of combining these two surgically incompatible posts in the same hands, it is curious that a foreigner, and one not then even naturalized, should have been appointed to this office, when there were dozens of capable surgeons in the neighbouring University town equally if not more fitted for the post. However, to appoint a surgeon at all was a step in the right direction.

When I was in office the consequence of the neglect of surgery was, from the patients' point of view, deplorable. Not only were cases that needed operation not operated upon, but such operations as took place had to be performed with blunt and dirty instruments, and in surroundings that were anything but aseptic. It was not long after I commenced my asylum duties that a patient one evening cut his throat. He had secreted a piece of broken china in his mouth, without the attendants discovering it, and when put back into his room had cut his throat with it. It was a very bad and extensive wound, and though the main bloodvessels were not severed, the patient was in imminent danger of his life. Of course, the wound had to be stitched up at once. He was taken to the hospital, and an improvised operating table was hastily rigged up in the bathroom! The available instruments were brought from the dispensary, but there was no means of properly sterilizing them. There was a very bad light, and only unskilled male attendants to act as dressers. Fortunately, the patient's condition was good, and he made an uninterrupted recovery, the wound healing by what is called "first intention," i.e. without any suppuration. But it was more by good fortune

than anything else that this result was obtained. In most cases a wound so caused and treated would have become septic, and the patient would have died from secondary pneumonia.

Not only have operations in most asylums to be performed under these unhygienic conditions, but the after-dressings of the cases are too often left in the hands of hospital attendants who have had no surgical training. Can it be wondered at that asylum surgery is in so hopelessly backward a state? And yet asylum patients suffer from numerous ailments that require prompt and efficient surgical aid. It is no exaggeration to say that in most of the public asylums in this country patients die every year whose lives might have been saved by a competent surgeon, were such available, the very existence of the maladies they suffer from being undiagnosed, and often unsuspected.

Mention of the lack of proper hospital arrangements in most British asylums leads naturally to the cognate question of the lack of a proper up-to-date surgery. In one of the asylums in which I served there was no proper surgery at all, the room used for this purpose being really part of the dispensary. Not only was it small, badly lighted in the daytime, and badly fitted, it was always horribly dirty and untidy. There was no special surgery attendant or nurse, the dispenser being supposed to look after the place and keep it clean, which he never did. It was very much the same in the other asylum, and I very much doubt if there is a properly equipped and up-to-date surgery in half a dozen of the ninety or more public asylums in the United Kingdom. Yet no such institution is more urgently needed in every asylum, large or small. Not only should there be a scientifically equipped surgery on the male and female sides of every asylum, but it should be under the charge of a special attendant, preferably a trained hospital nurse. All instruments should be sterilized before use, and thoroughly

cleaned and stored away afterwards. Instruments for special emergencies, such as tracheotomy, strangulated hernia, etc., should be kept in special cupboards, easily accessible. There should be a plentiful supply of surgical dressings, bandages, towels, etc., and several lavatory basins, with hot and cold water laid on; while the antiseptic solutions in ordinary use should be kept in large bottles, constantly replenished. There should be a sterilizer, a dentist's chair, a folding operating table, and a sofa among its equipments. The room should be well lighted, both naturally and artificially, well aired, well warmed, and kept thoroughly clean. Every morning at the hour when the Medical Officers commence their morning round the Head Attendant on duty should assemble in the surgery all the patients requiring attention, such as cases for teeth extraction, surgical dressings, etc., or patients who complained of feeling ill, and who needed medical examination. In this way much valuable time would be saved, nothing would be overlooked, and cases of serious illness would be diagnosed on the spot and at once sent into hospital.

There should also, if the authorities can afford it, be an X-ray department established in all the larger public asylums, which should be under the charge of one of the Medical Officers, who should be specially qualified for the work. This may seem to some critics an unnecessary expense and a counsel of perfection, where lunatics are concerned. But it is difficult to see why. Most cottage hospitals in small provincial towns are nowadays considered imperfectly equipped if they have not an X-ray installation, and it should be no more difficult to provide this in the case of County Asylums, most of which are situated near large and very wealthy county towns. Why should our insane poor be worse off in this respect than our sick poor? Accidents, such as fractures, are constantly occurring among asylum patients and attendants, and there are many other forms of internal disease

upon which examination by means of X-rays is likely to throw light, while its use as a possible method of treatment in selected cases is not to be ignored.

I have already alluded to the benefits that would result from the appointment of a visiting dental surgeon to all large asylums. This, again, may seem to be an unnecessary expense and a treatment of doubtful value and impossible of application in the case of the majority of mental patients. The objection on the score of expense may be dismissed in a few words. If not relevant in the case of hospital patients, why should it be so considered in the case of asylum patients, for they are both drawn from the same class? And for teeth stopping and mechanical work it might be possible to charge the relatives a small fee. A more general and more pertinent objection would be that dental treatment was impracticable among the insane, and might expose the operator to unnecessary risks where the stopping of teeth was concerned. As a matter of fact, however, the same objection would apply to teeth extraction; yet extractions are performed as part of the medical routine of every asylum, and no harm follows. The insane as a rule bear pain very well, and in the course of many scores of teeth extractions during my term of office I never had any trouble with a lunatic. And no anæsthetic, not even cocaine, was used in any case. It may also be objected that pauper lunatics belong to a class that does not get its teeth stopped, but prefers to leave them to decay until they are bad enough to need extraction. This may be true, but it is not relevant. No lunatic need have his teeth stopped or extracted unless he likes. But it is an important part of the treatment of that chronic dyspepsia which is associated with most forms of insanity that defective teeth should be removed or, when possible, restored. It may even be regarded as a supplementary treatment of the conditions upon which insanity itself so often depends, if not for its cause, yet often for its

continuance, viz. the conditions of physical ill-health. Improve a lunatic's physical health, of which good digestion is one of the most important factors, and his material comfort, and with it probably his chance of mental recovery, are so much the more increased. In reality, this question of the treatment of a lunatic's teeth is part of the far larger question of the dental hygiene of the poorer and uneducated classes generally. An infinite amount of harm to the general efficiency and health of the working classes is involved in the matter of defective teeth, as we had abundance of evidence during the war. Tens of thousands of young men were rejected as unfit for military service on account of defective teeth, and there is no question that the deficiency has as great or greater effects in civil as in military life. It is high time that a national crusade was started upon this subject, and under the new-born Ministry of Health it is hoped that such will be the case. Defective teeth and defective eyesight are responsible for more working inefficiency than all other causes combined. There is no reason that I know of why lunatics should not be given the opportunity of having their teeth restored and their working efficiency improved by proper attention to their teeth. I would even give those convicts who were undergoing long terms of imprisonment the same advantages. We consider it our duty to repair broken limbs and perform necessary operations in both cases. Why, then, should we not attempt to repair broken constitutions as well?

Of similar importance, if not to the recovery, yet to the comfort, of pauper lunatics is the question of their eyesight. While I do not think the appointment of a visiting ophthalmic surgeon is necessary, I regard it as essential that adequate facilities should exist for testing the eyesight, and providing proper glasses, for asylum patients. This could be quite easily managed by the Medical Officers themselves, for all medical men should

be cognizant of the simple principles of refraction work, and should be able to prescribe glasses for uncomplicated cases of defective vision. Yet in the asylum where I held office longest no ophthalmic test-lenses were kept, and the provision of spectacles for those who needed them was largely in the hands of the Head Attendants. A certain number of spectacles were kept in the asylum, and these were given out to such patients as were allowed to have them. But it was a very rough-and-ready method that was employed. There was no proper sight-testing—the patients tested the glasses themselves. If they suited them, well and good; if they did not, they had to use what they were given, or go without. It was a very unsatisfactory process, and if no great harm resulted, much annoyance and unnecessary deprivation was often caused. Reading is such an important factor in the treatment of mild and incipient mental cases, by giving congenial occupation as well as mental recreation and amusement to such patients as are capable of them, that it should be encouraged in every way possible. Many patients, of course, cannot be trusted with glasses, but far too much is left to the discretion of the attendants in this matter; and I have often been able to give permission to use their spectacles to patients whom the attendants regarded as unfit for this privilege.

I have mentioned in a previous chapter the importance of not detaining in asylum patients who, although obviously not quite sane or mentally normal, could be trusted with provisional liberty, such in fact as were not likely to become a source of danger to themselves or others, and whose friends were able to support them, and agreed to accept responsibility for their good behaviour. Large numbers of such patients are discharged "on trial," or to "the care of friends," under these conditions as it is, but a large number are detained in asylums who come under this category, either because their friends do not wish to be bothered with them, or

because no medical interest is taken in their cases. I fully recognize the difficulty which exists with regard to many of these cases, and Superintendents are not to be blamed for erring on the safe side where such are concerned. It is the inelasticity of the system that is chiefly at fault. The trouble is in most cases that there is no means of finding out, except by discharging them, whether such patients conform or not to the conditions specified above. For this reason I am a strong advocate for the employment of a modification of the "ticket-of-leave" system, which is applied to well-behaved convicts who have served part of their time, and who are allowed their liberty contingent on their complying with certain regulations. Patients provisionally discharged on such a system would be "on trial" like those now so discharged, but the "trial" would be more elaborate and more prolonged. One of the conditions of their release should be that they should report themselves every three months to the Superintendent of the asylum from which they came; or, if they lived at any distance from it, to the Medical Officer of Health of their district, to have their tickets viséd and endorsed. If, before twelve months was up, the Superintendent, or the Medical Officer of Health, saw any signs of returning, or increasing, mental trouble, or if the police produced evidence to the same effect, it should be within the power of the magistrates to sign a reception order, without the necessity of re-certification, and they could be at once removed to the same, or the nearest, asylum. Such a system would tend to protect the public, and would at the same time give a doubtful patient the chance of proving that he was fit to remain at liberty.

This regulation would apply to those who were actually discharged, but there are other conditions which might be applied within the asylum itself as a preliminary safeguard before this discharge took place. These would consist in an extension of the usual "parole" even now

allowed to certain selected patients in most asylums, but put to more definite use. Such patients might be allowed the freedom of the asylum grounds for a certain number of hours every day on "parole," the condition being that if they abused their freedom in any way they would forfeit the privilege. There is no doubt at all in my own mind that much more extended use might be made of this system of "parole" within the confines of the asylum, and in the case of the more dependable patients even outside it. Nothing is more likely to restore a patient's sense of self-respect than the feeling that he is trusted. In the Mental Hospital of Toledo, U.S.A., which is referred to in my concluding chapter, over 20 per cent. of the patients had "parole" of the grounds, and it was found that this privilege was seldom or never abused. When I once related this fact to a Head Attendant, he could not conceal his astonishment. I gave him Dr. Knowles Stansfield's article in the *Journal of Mental Science* to read, and his amazement increased "Why," he said, "it's hardly like being in an asylum at all!" So inveterate, to the ordinary British attendant's mind, is the prejudice that a lunatic asylum, to be of any use, should resemble a prison. Whatever the explanation, the fact remains that in few British asylums that I have heard of is the benefit of parole adequately recognized as an essential part of the treatment of the insane. Only those who have tried it know its efficacy as a restorer of hope and self-confidence to minds sadly in need of both. The usual argument against the extended use of this privilege is that it would lead to attempts to escape, and would thus increase the work and responsibilities of doctors and attendants. But the smallest consideration will prove the fallacy of such an argument. It is not those patients who are most trusted who attempt to escape, it is those who despair of ever getting out, and who are reckless in consequence. Patients on "parole" feel their discharge "in the air," so to

speak, and ordinary prudence counsels them to do nothing to endanger its realization.

But in addition to "parole" of the asylum grounds, the discharge of suitable patients on "parole" should be much more widely practised in this country. This would be a still further stage of advance upon the "ticket-of-leave" system advocated above. If during that period their condition required a return to the asylum, no legal procedure for a re-commitment should be necessary. On the other hand, should such patients recover, they should, at the expiration of the period of "parole," be automatically discharged. To quote a leading American alienist:—

> No test, no method of examination affords a fairer or more trustworthy and practical means of judging a patient's ability to get along outside of an institution. (*Manual of Psychiatry.* Rosanoff. Fifth Edition, p. 118.)

In New York, in 1918, the number of patients out on "parole" from the thirteen State hospitals was 1,890. We have nothing in England to compare with these figures, just as in England we have nothing to compare with the out-patient clinics in American mental hospitals, or with the American system of "Psychiatric Social Workers," who follow up and keep in touch with "paroled" patients. Nothing shows more clearly than these facts the advance made in psychiatry in the United States, and how hopelessly behind we are in this country in all matters relating to the social responsibility of the community to the insane.

On the subject of alterations and repairs to asylum buildings a few words must be said. This matter is, as I have said, in the hands of the Visiting Committee, who apparently have it in their power to alter asylum buildings as they think fit (so long as they do not exceed a sum of £400 in any one year), and to judge what repairs are "necessary" (Lunacy Act, 1890, Sect. 266). As

regards "certificated institutions," under the Mental Deficiency Act, 1913, the Committee are *obliged* to "keep the institution in proper repair and condition," but this obligation apparently does not apply to asylums, though why this should be so I am unable to say. That it does not may possibly explain the action, or rather inaction, of the Committee in the case of one of the asylums in which I served. The buildings of this asylum had been in a shocking state of repair for many years, even antedating the war. The roofs of the main buildings, as well as much of their interior, were falling to pieces in many places, and in wet weather the water used to penetrate everywhere, and the whole asylum was in need of thorough renovation and redecoration. But nothing was ever done on any comprehensive scale, and it seemed as if the Superintendent was willing to leave this very heavy, very necessary, but very unpopular, expense to the initiative of his successor, his own term of office being nearly up. I have reason to believe that, on a fair estimate, the expense involved will now run into at least £20,000, much of which sum might have been saved, had the repairs been taken in due time. The Committee, of course, were chiefly to blame; but to a Committee who so manage, or rather mismanage, the important question of asylum repairs, it is obvious that the final decision in such a matter should not be delegated. This is another argument in favour of my contention that a district inspector or surveyor, subject to the authority of the local Boards of Control (*vide infra*), and independent of the Visiting Committee, should be appointed to every county and report directly to the local Boards aforesaid, who should have the power on an order of the Minister of Health to enforce those recommendations, leaving it to the local authority to levy the required rate for this purpose.

There is only one more matter to which I need refe before bringing this chapter to a close, and that concerns

the installation of an up-to-date pathological and bacteriological laboratory, and the proper performance by a skilled pathologist (who should *not* be the surgeon to the asylum) of post-mortem examinations, at which the Medical Officer in charge of the case, at least, as well as the Medical Superintendent himself, should always be present. An enormous amount of information as regards the cerebral aspects and concomitants of mental disease is to be obtained by skilfully performed post-mortem examinations and efficient laboratory work. How is it to be expected that Medical Officers should take any interest in their cases, or be able to keep pace with the advance of cerebral pathology in other countries, if this important part of their work is systematically neglected? We were fortunate in possessing in one of the asylums in which I served a Senior Medical Officer of marked distinction and acknowledged authority in neurological and pathological research (he was the holder of a Government grant in these subjects), but no means were ever taken to encourage the acquisition and dissemination of such knowledge among the other Medical Officers.

CHAPTER XI

LEGISLATIVE REFORMS

It only remains to summarize briefly the suggestions which have from time to time been made in the course of these chapters for the reform of the present lunacy laws, and other suggestions which may now be added to them. It is pretty widely agreed among mental specialists and the medical profession generally that the Lunacy Act of 1890, and the Amending Act of 1891, were badly thought out, and provide a good illustration of legislation in a hurry. As it was undoubtedly the pressure of public opinion which led to the passing of these Acts, it is to be hoped that the same pressure, better informed and more wisely directed, may lead to their reform. When these projected reforms are discussed, it is imperative, as is stated in the concluding chapter, that an advisory committee should be appointed consisting of the Advisory Board of the Ministry of Health and assisted by representatives of various bodies, such as the British Medical Association, the Medico-Psychological Society, and a certain number of independent alienists of recognized authority, who should help the framers of the new Act in drawing up its clauses. For the present Acts have been so widely and adversely criticized that it seems better to repeal them altogether, and draft a new Act, than patch the old ones up again. Various medical bodies have met in recent years for the purpose of drawing up Reports on the alterations required, notably the Status Committee of the Medico-Psychological Society, and

another Committee of the same Society in 1918. The latter has now issued its Report, which contains many valuable suggestions. The Fourth[1] Annual Report of the Board of Control (1918) also makes many recommendations for the alteration of the present lunacy Acts. It is beyond the scope and purpose of this book to examine these suggestions and recommendations in detail, except in so far as they concern the case of the pauper lunatic, with which alone this book professes to deal. To these I must now refer, together with such other suggestions as I have had the temerity to make in the foregoing chapters.

The Words "Lunatic" and "Lunatic Asylum."

In the first place I would suggest that the words "lunatic" and "lunatic asylum" should be abolished from all the preambles and legal definitions in our lunacy laws, and the terms "persons of unsound mind" and "mental hospitals" should be substituted for them. The word "lunatic" not only carries with it a derogatory connotation, but it represents an archaic and exploded theory of the causation of insanity, which should no longer be authoritatively recognized. If the word "pauper" could be abolished in like manner, it would be a good thing, though it is difficult to see how a short and efficient substitute could be found for it. The expression "rate-supported person" is cumbrous, but some other might be suggested. With the disappearance of the Poor Law, the term applied to the recipients of Poor Law relief might well disappear also. It is significant that the term "pauper" does not, I believe, appear in legislative enactments in Germany. I state this fact, of which I have no personal cognizance, on the authority of Mr. W. H. Dawson, whose book on *Municipal Government* in Germany is an admirable contribution to this subject.

[1] As well as the Fifth and Sixth.

The Experiences of an Asylum Doctor

Incipient Insanity.

Chief among the legislative reforms, upon the necessity for which all mental experts are agreed, is that regarding the treatment of the early stages on insanity. At present the only course that can be pursued in England and Wales as regards the treatment of these cases is for the family physician to attend them in their own homes, or else to certify them as insane, and send them to any asylum. The first is directly harmful—the second often unnecessary. Many cases of incipient insanity are not serious enough to be certified, and thus have the social stigma of insanity (unfounded though this notion is) placed upon themselves and their families, and yet are too serious to be treated in their own homes, where the necessary supervision and control are not available.

In Scotland a patient can be treated with a view to cure anywhere out of an asylum for twelve months without formal certificates if a medical opinion to that effect, and proper intimation, is sent to the Board of Control (quoted from Sir T. Clouston).

This method has been attended with very good results, and there seems no reason why it should not be extended to England and Wales. I do not know whether it has been applied to Ireland. A certain modification of this system, which is known under the name of the "Voluntary Borders" system, is now legal in this country (Lunacy Act, 1890, Sect. 229), but it is extended only to the inmates of private asylums and registered hospitals. Under this system a patient may be received in either of these two classes of mental institutions for a specified time "at his or her request, and without certification, with the permission of two Commissioners in the Metropolitan District or of two justices appointed as Visitors under the Act of 1890 in the provinces." If the patient wishes to remain longer than the specified period, a new application and

permit has to be made and given, and in all cases he may leave such institutions at any time by giving the manager twenty-four hours' previous notice in writing. But pauper lunatics, who as a rule are not sent to private asylums or registered mental hospitals, are not thus provided for, and it seems only right that the system of voluntary boarders, for those who wish to avail themselves of it, should be extended to the case of those sent to public asylums.

This recognition and treatment of incipient insanity is a very important matter, and various suggestions have been made with regard to it. It is agreed on all hands that these cases should not be subject to compulsory certification, with its resulting "stigma," until they have had at least a chance of being successfully treated without it. Private patients can now take advantage of this privilege, but the case of pauper patients presents considerable difficulties.

At present the only place to which a poor person with the symptoms of incipient insanity can be sent without certification and for a limited period is the workhouse, where he at once comes under the jurisdiction of the Local Government Board, and becomes technically a "pauper." Between this and being certified as a "lunatic" and sent to an asylum there is at present no alternative. Dr. Weatherly and others have suggested that an outpatient department for early mental cases should be opened in all our large hospitals, which such cases could attend and where they could be treated. Though this is not strictly a legislative reform, a few words may not be out of place here on this point. To my mind, as far as treatment is concerned, though I recognize its advantages for teaching purposes, there are many and obvious objections to such a course. To begin with, our general hospitals are overcrowded as it is, and mostly in debt. Further, they are so situated, in the crowded centres of large and often manufacturing towns, as to be entirely

unsuitable for the treatment of this class of cases. Even if "annexes" could be built, or special wards opened, in these hospitals, the difficulty would not be met. A city environment is in itself unfavourable to the successful treatment of early mental disease; what is especially needed in these cases is fresh air, the opportunity for recreation and exercise, and peaceful and healthy surroundings. My own opinion is, as I have stated above, viz. that the case is best met by extending the privilege of voluntary boarders to pauper patients, and *by setting aside in our public asylums special quarters*, apart from the other patients, where such cases could be received and treated without certificates.

Asylum Visiting Committees.

Another reform which seems to me to be radically needed in any new Lunacy Act concerns the constitution and power of asylum Visiting Committees. It is impossible to forecast what will happen to the administration of our public asylums when the newly formed Ministry of Public Health takes over the authority at present exercised by the Local Government Board in all that concerns Poor Law legislation. Probably there will be a considerable devolution of the authority now exercised by the Central Government to the local bodies, and so long as Parliament strictly defines the powers of these bodies, and of any subordinate bodies holding authority under them, while it retains in its own hands and embodies in its lunacy legislation such essential conditions as those regulating the size and construction of mental hospitals, the number of patients allowed to be contained therein, and the proportion of Medical Officers and attendants to patients, this devolution of authority will probably be all to the good. As much devolution, and as little centralization as possible, seems to be the secret of successful administrative government. The complete con-

stitution and powers of asylum Visiting Committees is a far too complicated problem for discussion in these pages, nor have I the ability, had I the space, to discuss it. My task is the humbler one of pointing out existing defects—the application of remedies must be left to more competent hands. I am convinced, however, that far too much is left at present to the discretion of these Committees, especially as regards the matters referred to in the preceding chapters.

The Medical Superintendent.

Of greater importance, even, than the powers vested in the Visiting Committee are the powers vested in the Medical Superintendent. These seem to me to be in need of drastic revision and curtailment. No Medical Superintendent of any public asylum containing more than a thousand patients (I think myself that five hundred would be nearer the mark) should be allowed by law to combine in his own person the duties of Medical Superintendent and Chief Executive Officer. His first duty should be recognized to be to his patients, and no other duties should be allowed to interfere with this. In order to secure professional efficiency, it should be compulsory on all holders of this office to possess a diploma in psychological medicine, as well as the degree of M.D. from a recognized University. No Medical Superintendent should be appointed under the age of forty, or who has not had ten years' previous experience as Assistant Medical Officer. And he should be compulsorily retired at sixty. The appointment and dismissal of this officer should be in the hands of the Ministry of Health, but it should be open at any time for the Visiting Committee or the Board of Control to recommend the dismissal of an incompetent and untrustworthy Superintendent on due cause shown, but with the right of appeal to the Advisory Medical Board of the Ministry of Health, or to such members of

it as the Minister of Health should appoint to represent him.[1] The salaries and retiring pensions of these officers should be fixed by Statute and on a definite scale according to the size of the asylum and the length of service.

The House Steward.

The appointment of a House Steward separate from the Medical Superintendent for all asylums above a certain size should be made compulsory by law, and should be in the hands of the Visiting Committee. Salary and scale of retiring pension of this officer should be fixed by Statute.

A Stocktaker.

The appointment of an independent stocktaker, to examine at proper times all asylum stores, and to report upon the same to the County Council, should be made compulsory by law. The appointment should be in the hands of the local authority, who should also have the power of dismissal.

The Assistant Medical Officers.

All Assistant Medical Officers should be appointed by the Visiting Committee, but no canvassing should be allowed. Their salaries and retiring pensions should be fixed by Statute, and should be on an ascending scale according to length of service. No Assistant Medical Officer should be appointed under the age of twenty-five, and none should be eligible for this office who are not the possessors of a diploma in psychological medicine, in addition to their medical degree or diploma. It is also advisable

[1] As things are at present, however medically incompetent a Superintendent may be, and however he may neglect his medical duties, there is apparently no means of dismissing him as long as he satisfies the Visiting Committee.

that all Assistant Medical Officers should have held the post of house surgeon or house physician at their hospitals.

Promotion of Assistant Medical Officers should be by seniority, and all encouragement should be given them to remain in the service of the asylum to which they were first appointed. They should be allowed to marry at the age of thirty, and free accommodation for married officers should be provided by the asylum authorities, either in or outside the asylum grounds. The number and duration of the vacations of the Assistant Medical Officers should be fixed by Statute, and every three years each officer in rotation should be allowed three months' leave on full salary, in order to make himself acquainted with psychiatric work in other asylums, and preferably in other countries.

To stimulate such acquaintance a travelling fellowship in psychological medicine of not less than £500 a year for two years should be endowed by the State, for which all Assistant Medical Officers should be qualified to compete.

The Visiting Committee should have the power to dismiss any Assistant Medical Officer on good cause shown, but this dismissal should be subject to appeal to the Advisory Board of the Ministry of Health.

Discharges of Patients.

A Discharging Committee should be constituted in all public asylums, consisting of the Medical Superintendent, together with the Senior Assistant Medical Officers on the male and the female sides of the asylum, and the Medical Officer in charge of the case; and *this Committee should be so constituted by law.* The final decision should be in the hands of the Medical Superintendent. The duty of the Discharging Sub-Committee of the Visiting Committee should be confined to signing the discharge papers, and should include a personal examination of the patients. The legal responsibility for all such discharges should be vested, as heretofore, in the Visiting Committee.

THE MALE AND FEMALE ATTENDANTS.

The provisions of the Lunacy Act under this head should include :—

(1) The fixing of the proper proportion of attendants to patients.
(2) The hours of work and rate of wages.
(3) The compulsory recognition by all asylum committees of the National Asylum Workers' Union.
(4) The establishment of a probationary period of service, and the compulsory attendance of all attendants upon two courses of lectures given at the asylum during that period.
(5) The compulsory passing of an examination, as at present conducted by the Medico-Psychological Association, by all attendants, male and female, as a preliminary to certification.
(6) The compulsory registration of all attendants.
(7) The endorsement by the Visiting Committee of the dismissal of any attendant *for any cause* by the Medical Superintendent. (This should be in addition to the clause of the present Act, which compels the clerk of every asylum to send to the Commissioners notice of the dismissal of an attendant for misconduct.)

GARB OF ASYLUM PATIENTS.

All compulsory wearing of a distinctive dress by the patients in a public asylum or mental hospital should be prohibited by law, and permission to the patients to wear their own clothes, if so desired, should be given in every case.

MAINTENANCE CHARGE OF ASYLUM PATIENTS.

A weekly maintenance charge per head should be fixed for each county by the local Board of Control, after consultation with the Visiting Committee. This

should be divided under two heads, a *minimum* charge for food (other than that supplied from the asylum gardens and farm), and a *maximum* charge, which should include the other expenses of maintenance, including drugs and hospital requisites as specified in the Act. These maximum and minimum charges should be subject to alteration from time to time by the local Boards of Control, according to circumstances.

Letters of Patients.

Sealed letters from patients in all asylums or mental hospitals addressed to the Minister of Health should be sent unopened by the asylum authorities. A printed notice setting forth this provision should be conspicuously posted up in *every ward* of every mental hospital or private institution for the insane, and severe penalties should follow any breach of the law in these two particulars.

"Mechanical (and Other) Restraint."

The law relating to "mechanical restraint" in public and private asylums is sadly in need of revision. It requires strengthening in some cases, relaxing in others. It should be clearly defined in the Act that locked rooms are a form of such restraint, and that clause of the Act which provides for continuous personal supervision by an attendant in all such cases by day or night should be rigidly enforced. It would, in my opinion, be better to abolish the locked room altogether in the daytime in the general wards, except for the treatment of violent cases, which should only be permitted on the order of the Medical Officer in charge. "Seclusion" as a form of treatment may occasionally be necessary and permissible; but as a form of punishment it is unconditionally to be deprecated, and should be abolished altogether.

But "mechanical restraint" of some kinds, including the locked room in special cases, and under proper safe-

guards, there must obviously be in all mental hospitals, and it seems to me that the framers of the present Act, in their efforts to safeguard the interests of the insane, have in this instance tended to over-reach themselves. Much more should be left to the discretion of the Medical Superintendent and Assistant Medical Officers in these cases. Restraint, as we have seen, may be mechanical, medicinal, or manual. Yet the only one of these forms which the Medical Officer is obliged to enter in the books, and records of which have to be forwarded to the Commissioners every three months, is the mechanical. Yet it may well be, as Dr. Weatherly and others point out, by far the least dangerous or harmful of the three. Drugging, for instance, may have to be pushed to extreme limits before a patient can be deemed to be properly "restrained" by this means. Manual restraint, again, means, as has been stated, a more or less continuous fight between patient and attendants, in which grievous bodily harm may be done to the former; and has the disadvantage of not being amenable to adjustment and control like "mechanical restraint," and introduces the human element of temper and vindictiveness. None of these objections apply to "mechanical restraint" when properly supervised and controlled. In my opinion, restraint by powerful drugs, such as croton-oil, hyoscine, veronal, etc. should be resorted to much less frequently, and should be subject to much more careful supervision by the Medical Superintendent, while manual restraint should be abolished altogether.

The Board of Control.

The question of the Board of Control is a very difficult one, and the suggestions that I have to make on the matter are purely tentative. It appears to me, however, that many of the administrative evils from which our asylums suffer depend upon the centralization of the Board of Control in London, which causes it to be out of touch

with the provinces; upon the present mode of election to this body; and upon the fact that far too much and too varied work is exacted from the dozen or so members of which it is constituted. A better plan would be to abolish the Central Board of Control altogether, and in its place to elect local Boards of Control in each of the counties which contain County and Borough Asylums, regarding the Metropolitan area as one such county. These County Boards might consist of two members, one legal, one medical, and their duties should be to visit, not annually, but bi-annually, every County and Borough Asylum, private asylum, registered mental hospital, certified house, lunatic ward of workhouses, as well as every patient in private care, and to furnish bi-annual reports upon these institutions and all such patients to the Ministry of Public Health, who should cause these reports to be summarized and published in the leading London papers; while those parts of the reports dealing with each county should be published as well in the leading county press. These reports should be submitted in the first place to the Advisory Medical Council, which I presume will be one of the newly-formed Departments of the Ministry of Health, and will sit as a permanent Medical Board of Health in London, including among its members two or three leading alienists. The election of the County Boards of Control should be in the hands of the Minister of Public Health, and the salaries of the members of these Boards should be fixed by the State. The Metropolitan area being so much more important, owing to the larger number of asylums it contains than any of the provincial areas, would possibly need a larger Board of Control. This decentralization of the London Board of Control, and its practical abolition, would save a large sum of public money annually in the travelling expenses at present paid to its members, and the local Boards which took its place would be in much more intimate touch with the provincial affairs and needs than any London Board

could be. Retired Medical Superintendents of asylums should not be eligible for election to these Boards.

The Magistrates.

All magistrates, stipendiaries, and Justices of the Peace, should have the power of signing reception orders for the admission of the insane into mental hospitals. Under the present system, especially in the Metropolitan area, undue delay is often caused by the inability to find a magistrate competent to sign these orders in urgent cases.

All lunatics "found wandering or not under proper control" should be examined by the judicial authority either in their own houses, or, if such an examination takes place in a police-court, the proceedings should be *in camera.*

Epileptics and Imbeciles.

All pauper epileptics, if not actually insane, should be sent to special "epileptic colonies"; and all mental defectives of the pauper class, not convicted of crime, should not be sent to workhouses, or general asylums, but should be segregated in special colonies, like epileptics.

Note.—I do not know how far many of the reforms suggested in the preceding pages would be feasible or workable in practice; in particular whether the wide distribution of authority suggested in the management of public asylums, involving the Ministry of Health, the Boards of Control, the County Councils, and the asylum Visiting Committees would lead to an unworkable clash of powers and interests. The object aimed at, of course, is to make as many representative bodies as possible jointly and severally responsible for the proper administration of our asylums, and to prevent the secrecy and abuse of powers exhibited under the existing régime.

SUMMARY OF SUGGESTED ADMINISTRATIVE REFORMS.

The administrative as distinct from the legal reforms suggested in this book may be briefly summarized. The more pressing consist of :—

Legislative Reforms

1. The building of no more barrack asylums, and the gradual conversion of such as exist into asylums constructed on the " villa " or " cottage " system.
2. The appointment of visiting physicians and surgeons to all public asylums, and of a visiting dental surgeon.
3. The provision of an up-to-date operating theatre and surgery, together with an X-ray department, and a consulting-room for Medical Officers.
4. The provision of weighing machines and locked patients' letter-boxes in every ward.
5. The provision of a separate mess-room, and recreation-room, which latter should contain a billiard-table and a piano, for the male attendants, and a corresponding room, containing a piano, for the female attendants.
6. A much more comprehensive and varied dietary for the patients and attendants, with a liberal supply of fresh fruit and vegetables. Far more careful supervision in the preparation, serving, and cooking of food.
7. Better provision for the open-air and isolation treatment of consumptive patients, and the adoption of veranda wards for such.
8. A thorough revision and simplification of the rules for keeping Case Books, and the delegation of all non-medical clerical work, where possible, to the office clerks.
9. A much more general and comprehensive use of " parole " in suitable cases, and the institution of a modified " ticket-of-leave " system for patients discharged " on trial."

CHAPTER XII

THE IDEAL ASYLUM

HAVING in the foregoing chapters made many suggestions for the improvement and reform of the existing administration of public asylums in this country, it seems fitting, before bringing this study to a close, if I point out briefly the lines upon which what one might call the "ideal asylum" should be constructed and administered. Ideal asylums, like ideal republics, may be far from realizable at the present day, but as part of that social Utopia to which all good social reformers look forward, and which it may be hoped will *ultimately* be hastened, rather than retarded, by the Great War, though the signs of its advent are still far distant, it may not be amiss if we give the matter some serious consideration. Fortunately, we are not altogether without a guide to our speculations. There are in existence in other civilized countries, notably in Germany, Switzerland, and the United States, public asylums, or mental hospitals as they are properly called, which have at least pointed the way along which reform should be conducted, and have also advanced along it much farther than we have done in this country, with one or two inconsiderable exceptions. Some years ago Dr. Knowles Stansfield, the Superintendent of one of the London County Council asylums at Bexley, Kent, whom I have found reason to differ from on several occasions earlier in this book, published in the *Journal of Mental Science* (1914) a very interesting article on "The Villa and Colony System for the Care and Treatment of

Cases of Mental Disease." In this article Dr. Knowles Stansfield gave the results of an extended tour of investigation into the asylum treatment of the insane which he had conducted on the Continent and in the U.S.A. As an introduction to this chapter I cannot do better than quote extracts from the article in question, though the whole of it is well worth careful perusal. He says:—

Alt Scherbitz, near Leipsic, may, I think, be looked upon as the mother of the villa system of housing the insane. It is really a village populated by insane persons. On the one side are the receiving houses, the villas for refractory patients, and the sick, aged and infirm patients. On the other side is the colony for the quiet working patients, the villas for the men being separated from the villas for the women by the Medical Superintendent's house and garden, the farm buildings, farmyard, and industrial buildings. About one-third of the patients are housed in the colony and *form a hive of industry* (italics mine). Germany has shown great appreciation of the villa or cottage system, and most, if not all, of the institutions for the insane in that country that have been built during the last twenty years have been of this type. Viewed from the administrator's point of view, there are no special difficulties to be overcome in conducting the affairs of a villa asylum. *The villa system offers facilities for efficient classification which are not yielded by the barrack type of asylum.*

The institution, however, which I consider most nearly approaches the ideal asylum that I ever had the opportunity of seeing is that of Toledo, in Ohio, U.S.A.

This institution was built entirely on the villa system. It consisted of forty separate buildings, twenty-six of which were occupied by the patients. The buildings were arranged in the form of a hollow rectangle, bisected by the administrative buildings, the one side occupied by female patients, and the other side by male patients.

The buildings at either end completing the square were occupied by the violent and noisy patients. The cottages had each a veranda overlooking the square. The size of these squares, each of which formed a recreation ground, was large enough to allow of baseball, cricket, and football being played there.

Without leaving their cottages, the sick and infirm were able to witness the games played. The refractory patients in like manner were able to watch the games without leaving their verandas.

Each cottage was a simple two-storied brick structure, and

they were placed about twenty yards distant from each other. They were not connected with each other in any way, or with the administrative buildings, and the arrangement of each cottage depended upon the class of cases to be treated there.

In the grounds were three ornamental lakes, each about two acres in extent, and from four to five feet deep. These lakes were said to be a source of great pleasure to both patients and staff. They served for rowing and swimming during the summer, and for skating during the winter. Whilst I was there a number of patients were amusing themselves by fishing.

Over 20 per cent. of the patients had parole of the grounds. The gardening was done entirely by the patients, without the assistance of paid men, the head gardener being himself a patient.

The general appearance of happiness and contentment I have never seen equalled in any asylum. . . . In a word, they enjoyed a maximum of all that is best in the life of a model village, whilst, on the other hand, the irksomeness and restraint of institution life was minimized to a degree.

The first thing that will strike the reader on perusing this description is its extreme unlikeness to the picture I have given of the chief asylum in which I worked, with its prison aspect, its forlorn airing-courts, its dilapidated buildings, and its general air of squalor and gloom. (I refer to the actual asylum buildings and precincts, for parts of the asylum grounds, which the patients were not allowed to frequent, were quite beautiful in summer time.) In the mental hospital of Toledo, which, it should be remembered, was a real mental hospital in actual existence, there were no patients walking round and round an enclosed and barricaded space, clothed in pseudo-prison garb, and in winter shivering with the cold; there was no "exercise-pen" for the refractory and troublesome patients; there was no "behind-the-table" treatment; there were no unwarmed and pitch dark isolation "cells," in which patients were confined for weeks and even months together; and I make bold to say that there were no "closet-barrow gangs," or if there were, that they were properly treated, housed and fed. In fact, no contrast could well be greater than the picture drawn by Dr.

Knowles Stansfield of the mental hospital at Toledo and the picture I have drawn in this book. And the probability is that the contrast between the administration of the Toledo asylum and that of most British asylums was as great as that between their material and physical aspects. Most striking is Dr. Knowles Stansfield's testimony to the "general appearance of happiness and contentment" which he saw upon the faces of the patients in the American asylum, for there can be no greater test of the efficiency of asylum administration than this. When I remember the despair, dejection, disgust, apathy, and general boredom which were the prevailing facial expressions among the patients over whom I had charge, I think I can put my finger upon the cause of the low and decreasing recovery-rate in most British asylums. It is due not merely to the poorness of the food (upon which I do not wish to lay too much stress, for my asylum experience was limited to the period of the war, when all food conditions were necessarily bad), but to the monotony and dreariness of their lives; the absence of interesting employment and healthy recreation; the lack of personal freedom; the rigour of discipline; the want of imagination and sympathy on the part of those in charge of them, doctors and attendants alike; the neglect of all remedial and curative efforts—in a word, to hide-bound officialism. And there will never be an improvement in the recovery-rate until there is a corresponding improvement in the conditions that conduce to it, of which improvement those conditions specified in Dr. Knowles Stansfield's article may be taken as types.

There is no reason that I know of why mental hospitals of the Toledo type should not be in existence in this country. To pull down the present barrack type of asylums, and build others on the villa or communal system, would no doubt involve very great expense, and at the present time, when the national resources have been so enormously depleted by the war, such an expense

could not be justified. And there is the difficulty that suitable land for the construction and organization of such mental institutions is not often available in this country in the immediate neighbourhood of large towns. But if every asylum were largely self-supporting, as it might well be, were dairy and poultry-farming, and market gardening on a large scale, as well as pig-farming, scientifically and generally practised, it would not be necessary for the village communities of the insane to be in the immediate neighbourhood of large towns. Such communities might well be situated in the country, where each might possess its own flock of sheep and herd of cattle, and have its own slaughter-house. In this way only groceries would need to be purchased outside, and groceries are always within easy reach. There would be no objection to such village communities containing each as many as four or five thousand insane inmates, if an adequate number of Medical Officers and attendants were provided for, and the land were available. The chief drawback of their distance from large towns would then be the absence of teaching facilities in the county hospitals and universities for the study of insanity, to which I referred in my last chapter as being best provided by asylums; but this is a difficulty which might be overcome in the case of university towns by a system of cheap fares for medical students.

The main difficulty is undoubtedly that of expense. But even here that is not altogether insuperable. No more barrack asylums should in any case be built, and such as exist should be gradually transformed into villa asylums, employing, wherever possible, asylum labour, and paying for it on the system, already suggested, of work-coupons. No doubt we should have to wait till building materials became much cheaper than they are at present, though much of these would naturally be provided by the existing buildings, as they were gradually demolished. At any rate, the land would not in this case

have to be purchased, and that is the chief thing that matters. "Where there's a will there's a way," and when once it is recognized that the only humane and scientific form of mental hospital is that constructed on the "villa" or "cottage" system, we shall have gone a long way to getting this system realized in practice.

There are many other suggestions which I should like to see carried out in the "ideal asylum" above indicated, and which do not seem to have formed features of the mental hospital in Toledo. To begin with, I should like to see an asylum store in the grounds of all such communal mental hospitals, where patients could purchase their own allowable "luxuries," such as extra confectionery, sweets, tobacco, snuff, playing-cards, notepaper, pencils, etc., with their own money or in exchange for work-coupons; for the purchase of these things out of their own pockets, or with money earned by themselves, would afford a pleasure greatly in excess of that conferred when these things are purchased for them by others, and would tend to restore that loss of self-respect which is the unavoidable accompaniment of loss of liberty. To make this loss of liberty as little felt and as little irksome as possible should be one of the main objects in view in all our treatment of the insane, for, as Dr. Mercier well says:—

> The endeavour should be, not to remind the lunatic that he is an exceptional being, but to make him forget it; not to put prominently before him the restraints upon his liberty, but to contrive so that he is as little sensible of them as may be (*Lunatic Asylums*, p. 134).

With this end in view, as much use as possible should be made in our "ideal asylum" of the system of "parole" within the grounds in selected cases, and this might be extended in exceptional cases to "parole" even outside the grounds of the asylum. As often as possible walks should be arranged, under the charge of attendants, in the neighbourhood of the asylum, and every opportunity

taken to make the lives of the patients as varied and interesting as possible. Suitable games should be at all times encouraged, and provision should be made in this respect for the younger medical men and attendants. There should be a church in the grounds of every asylum, with a Church of England Chaplain; and in very large asylums it might be even possible to have Roman Catholic and Nonconformist chapels. Subscriptions for the maintenance of these buildings might be sought from the respective religious communities. A general reading-room and library, a small gymnasium, a concert-room and dance hall, which might also be used for lectures, theatrical entertainments and cinema shows, together with grass and asphalt tennis courts (one covered), should be provided, and even a swimming bath, in the case of the larger asylums, might be added.

Another feature which should exist in such village asylums would be the provision of garden and vegetable plots for cultivation by the attendants and such patients as were capable of working them. Every year, too, there might be held in the asylum grounds a flower and vegetable show, open to the public, in which prizes were given for the best individual vegetable products and the best-kept gardens. In this way a healthy rivalry would be engendered, and the interest of the patients and attendants greatly stimulated in their garden work. Nothing tends to alleviate and humanize enforced confinement more than pleasant, healthy and useful occupation, especially when it is remunerative as well. Under conditions such as these, it is my firm belief that the recovery-rate in our public asylums, at present stationary and even receding, would go up by leaps and bounds, and asylums would become, what they are far from being at present, real mental hospitals and homes of recovery for the insane. If anything I have written in this book should tend to the realization of such ideal, but far from Utopian, conditions, I shall not have written in vain. Much of the

expense incident to and necessitated by these changes would be eventually recouped owing to the greater recovery-rate, and the fact that such asylums would be largely, if not entirely, self-supporting. And merely to have an ideal at which we can aim, though we cannot at once or altogether realize it, is in all efforts at social reconstruction an immense lever for improvement, and a moral stimulus as well.

My work is now completed, and what its results may be it is for the reader himself to determine. I have endeavoured to paint a true picture of the daily life of a pauper lunatic as it is led in one of our large County Asylums at the present day. It is not a pleasing picture, and in the course of drawing it I have been obliged to make many adverse comments upon the system of administration prevailing in these institutions, and upon the conduct of those in charge of them. But if I have "nought extenuated," I have "set down nought in malice." As stated at the beginning of the book, it is principles I have sought to attack, not persons; and though in the course of these investigations, and in the evidence by which they are supported, I have been obliged to rely upon my experience of particular institutions and those responsible for their administration, this was inevitable if the charges I was bringing were to be substantiated. But I have stated nothing in this book of which I was not a personal eye-witness, or of which the evidence in its support was not certified to by competent eye-witnesses, or was not a justifiable inference from the facts before me. There was certainly nothing which occurred in my experience resembling the acts of cruelty and injustice to which recent writers in *Truth* (January 21, 28, and February 4, 1920) call attention as occurring in more than one military mental hospital, and which I hope, in the interests of all concerned, will be made the subject of a Government Commission without delay. As these military

mental hospitals were in most cases merely County Asylums taken over by the War Office, and the Medical Officers and other officials dressed in khaki and given military titles, the reader will realize that little alteration or improvement in the system of asylum administration exposed and condemned in this book was to be expected from them. And my object in this book has been throughout the exposure of the *system* of asylum administration in vogue in this country, a system sanctioned by law, approved by custom, and fortified by official apathy and neglect. It is this *system* which needs above all things to be altered, and which reflects so adversely upon our psychiatric practice. It is this which encourages the suspicion, so prevalent among the poorer members of the community, from whose ranks our pauper lunatics are chiefly drawn, that our public asylums are merely a means for incarcerating, not treating, the insane, a suspicion which I think I have proved to be abundantly justified. In a sense, Medical Superintendents and the Medical Officers of these asylums are themselves victims of this system, and cannot be held entirely responsible for the defects and abuses to which it gives rise. The Visiting Committee, and the Board of Control itself, are not without blame in this matter, especially the Board of Control. It has ample powers under the Act, and the members of which it is composed are paid adequate salaries, though, no doubt, they are much overworked. They are paid to inspect and report, and there is no excuse for the fact that their inspections are so perfunctory, and their reports on the whole, though recent improvement is to be noted, so stereotyped and misleading. That the facts disclosed in this book could exist without their knowledge, or at all events without their reprobation, proves, at any rate, that they were either strangely ignorant of, or lamentably indifferent to, them.

It was the spectacle of the treatment which for two years I saw daily meted out to the patients in our public asylums

that prompted me to write this book. I saw thousands of so-called pauper lunatics on both the male and female sides of the asylum crowded together in vast barrack-like constructions, with no attempt at classification or segregation: early mental cases, epileptics, general paralytics, suicidal and homicidal maniacs, imbeciles and idiots, melancholics, chronic dements, lunatics of every grade and type, indiscriminately congregated in comfortless, badly constructed, unhygienic, and totally unsuitable buildings. I saw these unhappy inmates confined at times for weeks together in pitch-dark, ill-smelling, mostly unheated, and locked-up cells. I saw them exercising in what were practically prison yards, insufficiently clad, in quasi-convict garb, exposed to all the inclemency of the weather, and subjected to a rigid and callous discipline. I saw them fed on ill-selected, innutritious, dirtily served and badly cooked food. I saw them suffer and die from various physical diseases, contributed to, if not actually caused by, the conditions of their asylum life, inadequately treated, and often, as in surgical cases, not treated at all; the tuberculous cases not isolated, even the tuberculous wards (as in one instance narrated in this book) shut up. I saw numerous patients punished by "seclusion" and otherwise for offences for which they could not justly be held responsible. I saw others systematically purged and drugged as an added means of punishment and restraint, and in default of humaner and more rational methods. I saw ex-service patients placed in asylums who should never have been put there, and other cases detained for years who, in my opinion, were fit for their liberty. I saw Superintendents, nearly the whole of whose time seemed taken up with office work, who took hardly any part in the medical treatment of the patients under their charge, who never made any effort to organize and develop systematic methods of cure, and whose chief object seemed to be to keep in with their Visiting Committees. I saw attendants subjected to arbitrary and

overbearing treatment, and their just grievances ignored, not only during the war, but after it was over.[1] I experienced in my own person all the senseless drudgery of a cast-iron routine, content to make men into machines, and careless how their work was done so long as petty rules were complied with. I saw Commissioners making their annual inspection, and with numerous administrative evils staring them in the face, apparently seeing nothing, and so ordering their reports that the general public was unaware that these evils existed. I saw sick and weakly patients denied such available "luxuries" as cream and eggs during the war, while Medical Officers in good health were given an abundance of nutritious food, often at the expense of the former. I saw Visiting Committees who seldom or never visited, at least in any systematic or thoroughgoing manner, and whose chief function seemed to consist in eating a monthly dinner at the asylum's expense. All these things, and many more of the same kind, I saw during my period of office in one or other asylum in which I served, and I reflected that if these evils and abuses existed in even one asylum, the probability was that the same or similar evils existed in most of the ninety odd asylums in this country; but that whether they did or not, it was my bounden duty to call public attention to them in the cases where I knew they *did* exist, so that, if possible, they might be remedied.

For the need of public education and enlightenment in these matters is very great. Not only is this the case as regards our treatment of the insane, but as regards the view we take of certifiable insanity, especially those types of insanity for which detention in an asylum is the only possible and justifiable form of treatment. The public for the most part imagines that insanity in all its phases connotes such hopelessly defective intelligence and aberration of conduct, that it matters little what

[1] There was a strike of the attendants in one County Asylum during my term of office.

may be the physical surroundings and mental and material environment of pauper lunatics, *so long as they are shut up*; that such lunatics have no intelligence, no feelings, no appreciation of what is done for their comfort, no desire for any amelioration of their state, but are reduced to the condition of mindless, and often dangerous, wild beasts, whose only source of enjoyment is the gratification of their animal desires and passions. Nothing, of course, in most cases could be farther from the truth. Except in the case of congenital dements, such as idiots and imbeciles, or of raving maniacs, or those hopeless dements who are far advanced in mental decay, the above description holds good of no class of the mentally affected. The majority of the insane not only have feelings, but they often have them in excess; not only are they not insensitive to their surroundings, but these have a very real influence on their health and happiness and their chances of recovery; and so far from being generically unintelligent, their intelligence is often acute, even though disordered. The "delusions" from which so many of the insane suffer are more defects of judgment or belief than defects of reason. So far from being unable to reason, and therefore to appreciate the frequent injustice of our treatment of them, many of the insane reason quite well; it is only when suffering from delusions that their reasoning, starting from insane premises, leads them to insane conclusions.[1] The rational faculty in such cases is not so much at fault as that it is imperfectly controlled and wrongly directed. The proper place for most of these patients, of course, is a mental hospital, for their actions are apt to be as badly governed and misdirected as their minds. But merely to confine such in asylums, while not making the slightest attempt to improve their mental

[1] Lunatics are not the only persons who reason wrongly. Probably as much perverse reasoning and defective thinking is exhibited by those responsible for the management of our public asylums as by those who are detained in them.

condition, is as inhumane as it is unscientific. We must in any case radically reform our whole asylum administration and methods of treatment, and no longer detain patients whose only mental defect is some harmless deficiency or abnormality for which their friends offer to be responsible.

But it is time that this book was brought to a close. It is for the public for whom it has been written to decide whether it has been worth writing. Not until they are made aware of what goes on in our pauper asylums, and are sufficiently interested to bring pressure to bear upon Parliament, is it likely that any improvement in the conditions I have described will take place. If every community has the laws and government it deserves, the same holds true of its public institutions, its asylums, its workhouses, its hospitals, its jails. The English voluntary hospital system is one of the finest in the world, and is the envy and admiration of most civilized nations, and by many it is supposed that this is due to the fact that it is a *voluntary* system, and is not yet under the control of the State. Nationalization of all public institutions may not be the panacea for administrative evils that some theorists believe, but whether it is or not, there is no doubt that an enlightened public opinion alone will remedy the evils inherent in this or any other system. The defects of bureaucracy are well known, and the existing state of our asylum administration is a sinister warning of what we may expect under State control unless we radically alter our methods of official supervision and let light into the dark places of bureaucratic government. As the reader of this book will be aware, I am all in favour of more Government control of asylums, but combined with control in essentials, there should be an absence of interference in non-essentials, and a delegation of authority, wherever possible, to properly constituted local bodies. Decentralization, in executive and administrative details, such as the setting up of provincial Boards of Control or Local Commis-

sioners in place of the Central London Board, seems to me as essential in the interests of administrative efficiency as the strengthening of Parliamentary control in all matters concerning the status, salaries, retiring pensions, etc., of asylum officials and the medical conditions governing the welfare of the insane. But the subject is a very difficult and complicated one, and for its adequate treatment needs the collaboration of many minds. The law in many of these matters seems to me to need strengthening rather than relaxing, and in framing its enactments the advice of medical experts and alienists should be relied on much more than has been the case in the past. There is far too much government by lawyers in this country, and far too little dependence on the advice of specialists in their own departments. Lawyers, no doubt, are indispensable to the framing of our legal constitution ; but laws, especially when they are laws relating to the treatment of the insane, should not be formulated by lawyers alone, but in consultation with responsible medical men with experience of the insane. Had this been done more generally when the last Lunacy Acts were framed, many of the anomalies and imperfections of these Acts would never have come into existence. It is to be hoped that when a new Lunacy Act is put upon the Statutes, the collaboration of responsible medical advisers will be obtained, so that these anomalies and imperfections may no longer figure in it. With a newly formed Ministry of Public Health, and a medical man as first Minister,[1] there is now a better chance for the rectification of the evils and abuses which have been the theme of this book.

[1] Dr. Addison had not resigned office when this was written.

POSTSCRIPT.

The greater part of this book was written shortly after the conclusion of the war, when all men's thoughts were set upon that social and industrial reconstruction which it seemed permissible then to hope the war would have brought nearer and made more practicable. The progress of events all over the world during the last two years has proved, alas! that few of such hopes are destined to immediate or near fruition, and the Author is reluctantly forced to conclude that many of the reforms advocated in this book, some of which involve a considerable outlay of public money, must be relegated perforce to more peaceful and prosperous times. None the less, he feels that to have drawn public attention to the very important and pressing matter of Asylum and Lunacy Law Reform has been amply warranted, and trusts that it may result in the claims of our Insane Poor not being forgotten in the better times which we all hope are coming.

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